| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | This visit was for the Recertification and State Licensure Survey.<br><br>Survey dates: April 11, 12 and 13, 2011<br><br>Facility number: 000347<br>Provider number: 155715<br>AIM number: 100275440<br><br>Survey team:<br>Marla Potts, RN, TC<br>Melinda Lewis RN<br>Sharon Whiteman, RN<br><br>Census bed type:<br>SNF/NF: 103<br>Residential: 27<br>Total: 130<br><br>Census payor type:<br>Medicare: 13<br>Medicaid: 53<br>Other: 64<br>Total: 130<br><br>Sample: 21<br>Residential Sample: 7<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.<br><br>Quality review 4/19/11 by Suzanne Williams, RN | F0000 | Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies.This Plan of Correction is prepared and submitted because of requirements under State and Federal Law.Please accept this plan of correction as our credible allegation of compliance. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>Based on interview and record review, the facility failed to ensure the physician was promptly notified of a resident's fall, complaints of pain, and x-ray results revealing a fracture, for 1 of 10 residents reviewed with falls in the sample of | F0157 | F 157 It is the policy of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 21. Resident #61<br><br>Findings include:<br><br>1. Resident # 61's clinical record was reviewed on 4/11/11 at 10:30 A.M.<br><br>Nurses notes, dated 3/29/11 at 10:45 p.m., indicated "Resident sitting on floor by bed of room (not her own) No bruising/skin tears. No outward signs of broken hips can abduct and adduct both legs without problem. No pop/click heard when moving legs, stood with transfers without problems with assist. Resident complains of left leg pain. Hydrocodone 7.5/500 given at this time. Updated Dr-asked if would like x-ray..."<br><br>The Post Fall Reporting Form indicated: "3/29/11 7:00 P.M. resident had a history of falls, observed on floor in resident's room (not her own), lost strength/weakness, activity during the incident was -ambulating in | | intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.I. Corective Action For The Resident Affected: The resident was sent to the hospital, received treatment for the right hip fracture, came back to our facility, and received therapy until April 22, 2011. Staff members involved in this resident's care were educated that they should have notified the physician by telephone of the resident's fall, complaints of pain, and fracture, rather than faxing the physician's office. A case review of this case was completed in the nursing education meetings on May 4th and 5th, 2011. Gaps in communication were identified and discussed. (Attachment titled Case Review).II. Other Residents Having The Potential To Be Affected: All residents requiring physician notification have the potential to be affected. The physician notification policy was reviewed on April 27, 2011. (Attachment titled Physician Notification).III. Systemic Changes and Steps To Ensure That The Deficient Practice Does Not Recur: Mandatory education will be held with all nursing staff, nurses and certified nursing assistants, on May 4th and 5th, 2011. (Attachment titled Required Education for Nursing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | bedroom (not her room), getting up from wheelchair, devices in use-chair alarm and anti roll back device, resident's physical status was weakness and unsteady gait, physician was notified 3/29/11 at 11:00 P.M."<br><br>LPN #1, on 4/11/11 at 12:15 P.M., provided a fax, dated 3/29/11 at 10:50 P.M. which indicated "found on floor-sitting by bed. No bruising/skin tears. No outward sign of broken hips can abduct and adduct both legs without problem-No pop or cluck lick heard when moving legs. Stood with transfers from floor to wheelchair and wheelchair to bed without problem with assist. Resident complaints of left leg pain would you like x-ray?"<br><br>Fall follow up documentation, dated 3/30/11 at 5 a.m., indicated injuries noted-2 bruises on left arm on and near elbow, area of scrape abrasion left upper leg, lateral aspect near knee, 1 bruise red in | | Staff). The physician notification policy will be reviewed in detail. It will be stressed that there are times when it is appropriate to fax the physician and there are times when immediate notification is required, such as for complaints of pain without an order for medication, an increase in pain that is not controlled, a fall, or a fracture. Staff will also be educated about the plan to prevent any delay in treatment for a resident with a fracture. All x-ray results will be reviewed by a second nurse to ensure that nothing is missed. Mobilex, our x-ray provider, will notify the director of nursing of all fractures. If unable to reach the director of nursing, the administrator will be called. Staff members were educated about this process in their April staff meeting and will be again in meetings held May 4th and 5th, 2011. An audit tool was developed that will be used by the Director of Nursing or her designee to ensure that physician notification is appropriate and timely for all residents who have experienced a fall. (Attachment titled Fall Audit Tool). IV. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | color .5 cm above knee, 3 reddish line, 6 cm length 1 cm width area not open, comments: "resident complains of leg pain at 2:55 a.m. complained pain being pretty bad. Hydrocodone/ APAP (narcotic pain medicine) 7.5/500 one given effective."<br><br>The Assistant Director of Nursing, on 4/12/11 at 11:00 A.M., provided a fax dated 3/30/11 at 7:30 a.m. sent to the physician which indicated: "right elbow .5 diameter purple bruise right lateral fore arm .5 diameter bruise, right mid thigh lateral aspect 3 red lines, scrape 4 cm by 1 cm no open area, right lateral thigh close to knee small .4 cm diameter purple bruise. Noted 2:45 a.m. gave shower." The physician had responded to the fax at 9:33 a.m. with no new orders.<br><br>Fall follow up documentation dated 3/30/11 at 12:15 P.M. "question if fracture left lower leg, to request order for x-ray from physician...comments: complains of | | random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop. The results of all audits will be reviewed by the Quality Assurance Committee monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | left groin/left hip pain, screams out with slight attempt with range of motion left lower extremity, complains of pain with flexing left foot in toward had, to request order for x-ray left lower extremity from doctor...resident has stayed in bed with no weight bearing or transferring no ambulation..."<br><br>Nurses notes indicated the physician office was called on 3/30/11 at 12:45 p.m. to request an x-ray order. Nurse notes indicated the Dr office called facility at 1:05 P.M. with new order "May obtain x-ray of LLE (left lower extremity), left hip, femur, knee, tibia, foot."<br><br>The medication administration records for March 2011 indicated an order for "Hydrocodone 7.5 mg/APAP 500 one, take one orally every 4 hours as needed for oa/right hip(osteoarthritic) pain." The Hydrocodone was documented to have been given 3/29/11 at 10:21 p.m. and on 3/30/11 2:55 a.m., 8:44 A.M., 3:47 P.M. and 10:55 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | P.M. The controlled drug record indicated the last dose of Hydrocodone administered prior to 3/29/11 at 10:30 A.M. was January 12, 2011.<br><br>The facility lacked evidence of having notified the physician timely of the fall on 3/29/11, but having faxed the closed office. The facility lacked evidence of having timely notified the physician of the residents increased complaints of pain and being medicated for left hip pain with Hydrocodone ordered for the right hip.<br><br>Nurses notes indicated the x-ray was taken with results called to the facility at 6:10 P.M. on 3/30/11. The results which included an acute fracture of left hip with modest displacement...faxed results to physician...."<br>Nurse's notes indicated 3/31/11 8:30 a.m. "spoke with doctor...on the phone about left hip fracture...indicated he would phone and speak with (family member) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | then contact orthopedic surgeon and call back." Nurse notes indicated an order to send to hospital was obtained at 10:15 a.m. and the resident transported on 3/31/11 at 11:15 a.m. The facility lacked evidence of calling the physician and ensuring he knew of the fracture on 3/30/11 when results were made available to the facility, further delaying treatment for the fractured hip.<br><br>The policy and procedure for "Physician Notification" not dated, obtained from the Facility Administrator , on 4/12/11 at 11:50 A.M., indicated: "1. If nursing is unable to reach the resident's family physician, the physician on call for the family physician is notified. If unable to reach the on call physician, the medical director is notified. 2. When notifying a physician of a resident's need/concern that needs prompt attention, state to the office personnel that fact. If no response is received within 2 hours, call the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | physician back. If no response is received within 2 hours, call the physician back. If no response call the medical director. 3. If the medical director is not reached or he does not respond timely, notify the Director of Nursing or the Administrator....5 This communication is documented in the resident's medical record..." | | | |
| F0250 SS=D | 3.1-5(a)(1)<br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>Based on observation, interview and record review, the facility failed to ensure a resident with behaviors was provided with social services in order to implement interventions which could be utilized by staff to manage the behaviors, of 1 of 8 residents reviewed for behaviors in the sample of 21. Resident #99<br><br>Findings include:<br><br>On the initial tour, on 4/11/11 at 10:15 A.M., LPN # 19 indicated Resident # 99 had dementia, and has had several falls and a recent fracture. Resident # 99 utilized a wanderguard, chair alarm and | F0250 | F 250It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.I. Corrective Action For Resident Affected: An interdisciplinary team review was completed on Resident #99 on April 28, 2011 to review her care, identify individualized interventions that would avoid the use of unnecessary drugs, and to provide appropriate activities and diversion. This individualized care plan was communicated to staff through the behavior care plan and through staff education. II. Other Residents Having The Potential To Be Affected: All | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | bed alarms.<br><br>The clinical record for Resident # 99 was reviewed on 4/11/11 at 11:45 A.M. The record indicated Resident # 99 had diagnoses that included but were not limited to dementia and anxiety. The MDS [minimum data set] assessment, dated 1/20/11, indicated Resident # 99 had impaired cognition, and had no behaviors.<br><br>The Nurses Notes, dated 10/20/10 at 7:30 P.M., indicated "Res back at nurses desk with purse in hand demanding to talk with daughter. Told res she had spoken with her just a few minutes earlier and res did not recall conversation. Stated that she would call her dad to come and pick her up if (daughter's name) couldn't. Unsuccessful with 1:1 [one on one] gave i [one] Ativan (antianxiety medication) 0.5 mg at this time for increased anxiety and nervousness..."<br><br>The Nurses Notes, dated 10/22/10 at 5:00 A.M., indicated "Awake and at nurses station from 11 p to 3:30 am. Dressed self carrying purse around wanting to leave. Continuously asking to go home, call daughter, call nephew. Redirected without success. Gave Ativan 0.5 mg at 2:37 am. Went to bed at 3:30 A..." | | residents with behaviors have the potential to be affected. An interdisciplinary team review was completed on all residents who exhibit behaviors on April 28, 2011. An individualized care plan and interventions were developed for residents that can be used to avoid the use of unnecessary drugs. These care plans are available to all staff in a binder at the nurses station.III. Systemic Changes and Steps To Ensure That The Deficient Practice Does Not Recur: Behavior care plans will be discussed and updated at each care plan meeting and as necessary on the nursing unit. Behavior care plans will also be reviewed in the behavior management meetings at least every six months and as appropriate. Mandatory education will be held on May 4th and 5th, 2011, with all of the nurses and certified nursing assistants to review this plan of correction. (Attachment titled Required Education for Nursing Staff). Nurses will be educated that the interventions that are attempted prior to medication administration should be documented in the paper medication administration record. An audit tool was developed to be used by the Director of Nursing or her designee to ensure that all individualized interventions and behavior care plans are followed prior to the administration of medication. (Attachment titled | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The Nurses Notes, dated 10/22/10 at 6:30 P.M., indicated "PRN [as needed] Ativan 0.5 mg given po [by mouth] at this time for increased agitation. Wanting to go home constantly asking to call family even though did talk with family."<br><br>The Nurses Notes, dated 10/22/10 at 10:00 P.M., indicated "Resident into roommate's items clothing/pictures and trying to throw items away. Daughter called, talked with res first then talked with writer. Daughter requested that writer call Dr (name) to see if res could get something else referring to medication. Writer called on call Dr (name). Gave order for Haloperidol (antipsychotic medication) 5mg/ml Give 1/2 (2.5 mg) IM [intramuscular] for agitation. Gave IM in L [left] ventrogluteal with compliance from resident. Prior to giving medication/IM res tried to tear up laminated copy of television channel that was roommate's. Writer took away..."<br><br>The Nurses Notes, dated 10/23/10 at 6:45 P.M., indicated "...Res anxious and nervous. 1:1 given but not effective in calming."<br><br>The Nurses Notes, dated 10/23/10 at 7:00 P.M., indicated "Gave Ativan 0.5 mg for anxiety..." | | Unnecessary Drugs Audit Tool).IV. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of audits, 100% compliance continues, auditing will stop. The results of all audits will be reviewed by the Quality Assurance Committee monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 10/24/10 at 8:30 P.M., indicated "Res back and forth from recliner to room to nurse's desk wanting telephone book or wanting to talk to her dau [daughter], grandson, sister or brother etc...unsuccessful in re-orienting and 1:1 sessions. Repetitive questions and nervous behaviors. Gave Ativan 0.5 mg i po for anxiety..."

The Nurses Notes, dated 10/24/10 at 11:35 P.M., indicated "Res anxious and agitated, refusing redirection yelling at nurse. Wanting to go home wanting dau to come and get her. Interrupting report, refusing to sit in recliner. MD notified gave order for Haldol (antipsychotic medication) 5 mg/ml give 2.5 mg IM for agitation now. May give 2.5 mg in 4 hours if remains anxious and agitated."

The Nurses Notes, dated 10/25/10 at 12:35 A.M., indicated "Gave Haldol 2.5 mg IM at 11:50 PM...Continues to be awake agitated at nurses station demanding staff to call daughter, nephew to come and get her. Went to roommate who was sleeping in recliner and shook her and woke her. Redirected again to sit in recliner..."

A Behavior/Intervention Monthly Flow Record, dated 10/25/10, indicated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | "Behavior 1. Agitation Yelling wanting to go home. Intervention codes- redirect, 1 on 1, toilet, give food, give fluids, call daughter."<br><br>The Nurses Notes, dated 10/27/10 at 4:30 A.M., indicated "Res awake at 11:15 PM roaming in halls and others rooms going thru roommate's belongings. Packing clothes carrying around. Attempting to get off unit. Wanting to go home. Tried to encourage to lie down in bed, recliner. Gave PB and J [peanut butter and jelly] and 240 (8 ounces) milk consumed both continued to be redirected in others rooms and asking to leave. Gave Ativan 0.5 mg po at 1:39 AM..."<br><br>The Nurses Notes, no date or time, (located between 10/27/10 5:40 P.M. note and 10/28/10 10:00 A.M. note), indicated "Anxious unable to sleep. In and out of bed in and out of room. Unable to be redirected d/t [due to] increased anxiety. Asked nurse for cup of water then stated Is the medicine in here? Res then said the medicine helps her sleep. Gave Ativan 0.5 mg at 12:40 AM..."<br><br>The Nurses Notes, dated 10/28/10 at 2:15 P.M., indicated "Daughter in to visit resident this afternoon. Noticed that resident seems to be oversedated from Ativan. Requested that Ativan be | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | decreased to only be given at HS [bedtime] and PRN. Called (name) at Dr (name) office and made aware of family request. N.O. [new order] to d/c [discontinue] 8 AM dose of Ativan 0.5 mg d/t oversedation. Continue HS dose and PRN 0.5 mg doses at q [every] 6 hours as needed for anxiety..."<br><br>The Nurses Notes, dated 10/28/10 at 10:20 P.M., indicated "Res up in room going through roommate's belongings insisting things were hers. 1:1 provided with no success. CNAs also trying to redirect also with no success. Res wants to speak with daughter (name) insisting on dau coming and picking up resident. Res given routine Ativan at 8 pm..."<br><br>The Nurses Notes, dated 10/29/10 at 1:00 A.M., indicated "Awake wandering halls into others rooms into roommates belongings in drawers. Very anxious at 11:15 PM shift change past several nights. Packs and carrys (sic) her belongings around wanting to go home wants staff to call dau nephew to pick her up. Res at nurses station and med carts demanding to get her a bag for belongings. Attempt to redirect distract by offering food fluid magazines word search 1:1. None of these interventions have been successful this shift. Ativan 0.5 mg po at 11:47 PM for anxiety/agitation..." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 10/30/10 at 12:50 A.M., indicated "Resd [resident] highly agitated restless up/down going down hallway entering other resd rooms...Resd going through roommate's clothes out in hallway and back to other rooms. Very anxious becoming upset. Ativan 0.5 mg i given for increased anxiety/agitation."

The Nurses Notes, dated 10/30/10 at 1:30 A.M., indicated "Resd going through roommate's clothes upsetting roommate would not go to her side of the room upsetting roommate still very anxious/agitation cont unable to redirect at present refuses to come to nurses desk CNA one on one with resd in room at present to help with roommate being upset as well."

The Nurses Notes, dated 10/30/10 at 7:30 A.M., indicated "Res packing belongings in trash can, hers and roommate's. Coming to hall and nurse's desk packing up papers any item she can reach others glasses books. Have tried 1:1 had bfast [breakfast] movie low lights denies pain. Unable to redirect. Looking sister aunt grandpa and my babies (sic) will monitor."

The Nurses Notes, dated 10/30/10 at 8:00

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A.M., indicated "Continues nonstop with above behavior have tried above distractions but res not re-directed. Ativan 0.5 mg po given at this time."<br><br>The Behavior/Intervention Monthly Flow Record, dated November 2010, indicated "Behavior 1. A. agitation B. yelling C. wanting to go home. Intervention codes-redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, give PRN Ativan, give PRN Haldol."<br><br>The Nurses Notes, dated 11/1/10 at 12:10 A.M., indicated "Awake and at nurses station at 11 PM. Interrupting during report. Continues with constant questions. Intrusive, looking through papers, folders, lab book, getting into cups and med cups in med cart. Was trying to touch med cards. Was constantly redirected, 1:1, offered food and fluid assisted with putting on pajamas. Wanting to call her grandpa and dad. Found res at door to dining room call light on above door. Door was then locked. Was also walking down hall past her room, entered res room across hall."<br><br>The Nurses Notes, dated 11/1/10 at 3:40 A.M., indicated "Gave Ativan 0.5 mg at 3:03 AM..." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 11/1/10 at 6:30 P.M., indicated "...Res walks up and down hallways. Going into other resident's room and going through their items."

The Nurses Notes, dated 11/2/10 at 5:30 A.M., indicated "Res anxious, agitated, intrusive, unredirectrable (sic). At nurses station until 2:30 AM gave Ativan 0.5 mg i at 12:20 AM, ineffective. Continued to be anxious, refused to sit or lie in recliner or bed. Rummaging in papers at nurses station. In bed at 2:30 AM had remained in bed since 2:30 AM."

The Nurses Notes, dated 11/3/10 at 8:45 A.M., indicated "Res up to nurses desk multiple x's [times]. I've got to go home. I've got a doctor's appt [appointment] Where is my pocket book? Where are my keys? I've got to go home. 1:1 [one to one] offered which calmed res some but continued to be worried about needing to be somewhere. c/o [complains of] L [left] cheek discomfort. PRN [as needed] Tylenol and Ativan given at this x."

The Nurses Notes, dated 11/5/10 at 6:50 A.M., indicated "Res has been intrusive into nurses station into all but 2 resident's rooms entire shift. Unredirectable (sic) did several interventions which were ineffective. Gave Ativan 0.5 mg i [one] po

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | [by mouth] at 3:17 AM was ineffective. Continued to go into rooms when residents were sleeping. Awakened several residents attempting to take res's belongings some res became upset attempted to hit this resident. Intervened several times took res out of room. Was yelling this is my house this is my room I can go wherever I want. This behavior continued entire shift res did not sleep from 11p - 7 a. Dayshift nurses notified of res behavior, DON [Director of Nursing] notified. Continues to be awake wandering in res rooms."<br><br>The Nurses Notes, dated 11/5/10 at 2:30 P.M., indicated "Awake all day active in and out of resident's rooms taking others belongings from their rooms eventually staff took items back. Res has been up in halls and lounge gathering items to go home..."<br><br>The Nurses Notes, dated 11/6/10 at 6:30 P.M., indicated "Res up at this time. Believes that this is her home and wants to know who disorganized her house. Upset that walkers in lounge by respective residents who need these walkers. This resident tried to move but staff redirected."<br><br>The Nurses Notes, dated 11/6/10 at 7:05 P.M., indicated "Res going in and out of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | other resident's room. making beds and going through closets/dressers. Very agitated when staff try to redirect. Res raises voice and states Get out of my house! Refused oral meds [medications] at this time: Klonipin (sic) and Depakote. Haldol 0.5 ml given IM R [right] ventral gluteus."<br><br>The Nurses Notes, dated 11/8/10 at 3:00 A.M., indicated "Res sitting in recliner at 11 pm trying to get out and go home. Asked to sit several times, clip alarm sounding said she had to get home. Spent 1:1 time, distracted with folding clothes, food, fluid, reading. Interventions unsuccessful continued 1:1 with res. In hallway, dragging blankets, purse and house slippers attempting to go into res rooms. Yelling at staff awaking (sic) residents in rooms. Ref [refused] to sit or lie (sic) in bed. Attempted to give Ativan in ice cream refused. Gave Haldol 2.5 mg IM [intramuscular] in L [left] buttocks at 1:15 AM. Was able to sit in recliner at 1:30 AM..."<br><br>The Nurses Notes, dated 11/9/10 at 5:30 P.M., indicated "...At nurses station asking for her purse. Asking repetitive questions per usual. Speaking with slow somewhat slurred speech. Insisting she is not staying here tonight. Staff attempting to redirect or re-orient without success. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Will continue to re-direct or re-orient to current living conditions. Staff cannot convince resident that family is aware. Will cont [continue] to monitor for any changes."<br><br>The Nurses Notes, dated 11/9/10 at 8:30 P.M., indicated "Resident in recliner with foot rest extended up. Res previously toileted, walked in bedroom and hallway, and changed into night gown. Continuously asking to call parents and siblings. Res thinks she is going home / going to church function. Res states she doesn't have a car to drive. Res tries to get out of recliner with foot res extended. Staff asks what needs are and res states I'm going home. Staff reminds resident that she has a bed here to sleep in. Writer helped resident get situated better in recliner and res kicked writer. Soon after an aide helped resident to get back in recliner when resident stated I will kick you in the guts. Aide then got kicked in stomach by this resident. Resident kicked with much force with both legs/feet. Staff tried to redirect/reassure resident that family comes in to see resident regularly and they know she's here. Another staff member stated that the doctor has authority to release this resident. Resident stated s--- on the doctor."<br><br>The Nurses Notes, dated 11/19/10 at 9:20 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | P.M., indicated "Walking up/down hallways. In/out of other resident's rooms. Not sleeping this shift. Tried to push on locked double doors to try to go out to car. Gathering/packing items to go home. Staff reminds resident that her family has paid for resident to spend night here. Staff reminds resident that we are here to help resident..."<br><br>The Nurses Notes, dated 11/26/10 at 2:10 P.M., indicated "Pharmacists made recommend (sic) after behav [behavior] committee met and discussed res sleeping during day and being awake at noc [night]. She freq [frequently] disrupts other res sleep at noc and isn't easily re-directed. Spoke with pharm [pharmacist] he suggested Melatonin 3 mg hs [bedtime] to help realign her circadian (sic). He said studies have shown good results when someone has to change time zones to adjust "clinically shows it works" no SE [side effects] or sedation. Also this has been discussed at length for this res d/t res ambul [ambulation]/mobility. Spoke with (daughter name) re: above, she said she's ok with this. Told her we will monitor res. Updated Dr (name) waiting response."<br><br>The Behavior/Intervention Monthly Flow Record, dated December 2010, indicated "Behavior 1- agitation, yelling, wanting to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."<br><br>The Nurses Notes, dated 12/2/10 at 6:30 P.M., indicated "Writer found res to be sitting on trash can in pantry/nourishment room, voiding into trash can. Staff redirected resident immediately."<br><br>The Nurses Notes, dated 12/11/10 at 2:10 P.M., indicated "CNA reported earlier this shift resident was sitting by Dogwood west end exit door with (number) et (number) residents as if she was waiting for an opportunity to exit. CNA reported res up at 5 AM. Resident yelled at (number) resident trying to take the basket of scarves from her. 12-10-10- 3-11 shift yelled at (number) resident that yells out occas [occasionally] to freq [frequently] et | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | cries to be quiet. Explained to resident that (number) cannot help it. Resident voiced understanding once explained to her."<br><br>The Nurses Notes, dated 12/11/10 at 1:30 P.M., indicated "Has been awake all shift. Has been in others rooms but didn't bother their things. Has collected a pillowcase of her things and carried it on the unit. Swept floor. Visited with other res..."<br><br>The Nurses Notes, dated 12/11/10 at 11:15 P.M., indicated "Res inspecting cords between wall and recliners in lounge area. Attempting to unplug cords. Writer concerned that resident might trip on cords and fall. Writer asked resident to let cords alone. Res stated If you don't leave me alone I'll throw you out that window. Resident finally left cords alone after multiple times of asking to leave cords alone."<br><br>The Nurses Notes, dated 12/14/10 at 10:00 P.M., indicated "Resident in lounge area getting behind recliners next to wall trying to unplug TV, Christmas tree et recliners. Very hard to redirect was insistent on unplugging the electrical cords. Daughter (name) called to help distract her with success."<br><br>The Nurses Notes, dated 12/25/10 at 3:00 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

A.M., indicated "Awake since 11 PM Into other resident's rooms multiple times. Unplugging lights to Christmas tree. Taking ornaments off tree. Staff redirects without success. Tore off garland off nurses desk and took to personal room."

The Nurses Notes, dated 12/31/10 at 6:00 P.M., indicated "Called dtr [daughter] to ease anxiety. Pt [patient] very anxious and looking for a way out. Gave prn [as needed] Ativan."

The Behavior/Intervention Monthly Flow Record, dated January 2011, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."

The Nurses Notes, dated 1/7/11 at 3:30

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A.M., indicated "Awakened from recliner walked toward another resident's room and threw res church program to the floor and attempted to take down stop sign across threshold to room. Attempted to redirect when res became angry and tried to turn off hall lights. Made a statement that I want these lights out now. I'm paying for these lights out of my pocketbook. Also tried to shake another res by grabbing her arm, stating those are my pajamas, get them off now. CNA's redirected res went to recliner sat down and closed eyes."<br><br>The Nurses Notes, dated 1/9/11 at 1:15 A.M., indicated "Up/down. Unplugging television. Redirection, 1:1 ineffective. Refused foods/fluids x [times] 1. Redirected to room (number) asking resident if wanted to clean. Refused to clean. PRN [as needed] Ativan 0.5 mg given at this time. Did accept in pudding."<br><br>The Nurses Notes, dated 1/10/11 at 8:43 A.M., indicated "Awake all morning walking around unit looking for glasses. wanting ankle roam alert bracelet cut off. Wanting her sister so she can cut it off. Have tried to redirect with sweeping folding laundry exercise walk 1:1 becoming upset that you won't cut this off and call my sister. Gave Ativan 0.5 mg at this time." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 1/11/11 at 4:20 P.M., indicated "Res up wandering in others rooms pilfering items from others rooms and placing in her room. Advised res that she was not to take things from other's rooms and res stated she was not a thief. Told her that I knew she wasn't but I understood that she gets confused at times. Redirected res to her own room and replaced items taken from other's rooms."

The Nurses Notes, dated 1/13/11 at 4:00 A.M., indicated "Res awake, wandering in halls and into other's rooms at 11:15 P.M.. Redirected offered food and fluids refused. Poured a cup of apple juice and sat on table for res. Behavior escalated when attempting to redirect. Yelling at staff and resident to get out of my house now or I'm going to call the police. Went behind recliners and pulled electrical cord out of wall for TV. Tried to push on TV screen. Continued to yell at CNAs. Went to res door and tried to pull wreath off door. Asked to come back to recliners, refused and yelled. Sat with res and looked at flower and seed magazine for 1/2 hour, gave Ativan 0.5 i [one] po [by mouth] at 2:06 AM."

The Nurses Notes, dated 1/13/11 at 9:00 P.M., indicated "Standing on chair trying to hang sheets up as curtains where blinds

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | are located- D wing lounge. Staff got res off chair and placed chair in different location. Blinds being pulled down by this resident. Staff trying to give resident foods and fluids to this resident but refused stating that staff members are making this resident loss (sic) appetite. Found another chair and began hanging sheets where blinds are. Chair taken by staff res safe. Attempted to call (grandson name) on cell phone but not good connection. Called daughter earlier in shift but has an infection (daughter's name) is sick and will let her rest per her request. Has grabbed at clothing of staff taking away chair. Res stated I will pound your head and I will knock the s--- out of you."<br><br>A Social Services Notes, dated 1/27/11, no time, indicated "Social Services spoke with Behavior mgmt [management] review team regarding resident's anger, agitation and verbal out burst. Dr (name) will be notified by nursing staff. Social Services will continue to support and assist PRN [as needed]."<br><br>A Behavior Management Team Review, dated 1/27/11 no time, indicated "Summarize the behavioral occurrences. Include number of occurrences in the past 30 days, possible causes, medical considerations, precipitating and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | contributing factors (if known). Review psychoactive medications to include reduction/increases and any side effects noted. Document team recommendations...Summary- Behaviors Monitored: anger, agitation, bossyness (sic), verbal aggression. Pattern (occurrences/interventions): almost daily. Precipitating Factors: unknown. Psychotropic Medication and Care: clonazepam 0.25 at 6p, lorazapam 0.5 PRN. Recommendation: Refer all to (Psych company name), possible med [medication] change, mini mental assessment to determine type of dementia."<br><br>The Nurses Notes, dated 1/27/11 at 12:00 P.M., indicated "Behav [behavior] mgmt [management] team met re: res increased behav and becoming more difficult to re-direct. Has used Ativan 6 x [times] past mo [month]. Recommend (Psych company name) consult since Dr (name) is back from sick leave. Dr (name) seen res while Dr (name) was out. Updated Dr (name) on this and asked if he's still ok with (Psych company name) seeing res. (Daughter name) states is fine with her."<br><br>The Nurses Notes, dated 1/27/11 at 1:40 P.M., indicated "At desk past hour asking for phone to call (daughter name) near tears have tried 1:1 [one to one] offered | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | drink and snack, magazine and office work. Becoming more upset. Call placed to (daughter name) she spoke with res 5 min. Res crying. (Daughter name) spoke with me and requested I give her Ativan. Gave 0.5 mg at this time."<br><br>The Nurses Notes, dated 1/27/11 at 7:00 P.M., indicated "Res going into other resident's rooms and rearranging regarding to resident's own wishes. Res becomes upsets (sic) when staff tries to redirect. Has refused 6 pm Klonopin x [times] 2. Asked resident if wanted to (daughter name) or (grandson name) (sic). Res response is No x 2. Res redirected to dining area to clean but resident refused and walked out of dining room and walking up/down wing hallway tearing down paper/decorations off doors and walls."<br><br>The Nurses Notes, dated 1/27/11 at 7:20 P.M., indicated "This res walking along side another resident who was holding a beverage in a cup. This beverage spilt (sic) on the floor. Witnessed by 2 staff members. Resident denied hitting cup of this other resident. (Daughter name) was called and asked to come in and help resident calm down."<br><br>The Behavior/Intervention Monthly Flow Record, dated February 2011, indicated | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."<br><br>The Nurses Notes, dated 2/6/11 at 8:04 A.M., indicated "Res up before 7 A shift. Has been going to other res asking why are you in my house! Who gave you permission? Pointing her finger in their face. Banging fist on desk. Explain why all these people are in my house? Tried talking 1:1 [one to one] with res. refused Bfast [breakfast] offered to dust furniture, wipe tables etc No! I want an answer. Gave Ativan 0.5 mg at this time."<br><br>The Social Services Note, dated 2/6/11 no time, indicated "Dr (name) was here today to see resident. No new orders were written. Social Services will continue to support and assist PRN."<br><br>The Social Services Note, dated 2/11/11 no time, indicated "Social Services | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | informed of fall. ADON [assistant director of nursing] to follow up. Social Services will continue to support and assist PRN."<br><br>The Nurses Notes, dated 2/11/11 at 6:00 P.M., indicated "...Resident walking around taking other resident's food that they didn't eat et [and] drinks that they didn't drink et trying to give it to other residents. Packed up a resident's clothing in (number). States that the clothing belonged to her was given to her. Very difficult to redirect. Used soft calm voice with approach. Tried to call dau [daughter] et gr son [grandson] without success- left msg [message] on voicemail."<br><br>The Nurses Notes, dated 2/11/11 at 6:25 P.M., indicated "Called grandson (name) et told him that staff has poisoned her food, et that she will not take her medicine because we are trying to poison her was upset with staff for calling gr son (name) d/t [due to] she didn't want to wake him up. Staff reported that resident hit at staff member twice. Resident occas [occasionally] pursing lips et breathing out with force. Grandson (name) stated that he will meet staff at chapel door in 3 minutes et that staff needs to bring resident's medicine to him so resident will not know that we gave it to him et he will | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | try to give resident her medicine to do so. Staff giving 1:1 [one on one] et keeping resident away from other residents as much as possible when needed."<br><br>The Social Services Progress Notes, dated 2/14/11, no time, indicated "Social Services received a referral form on 2/14/11. Social Service form stated res likes to be a mother hen wants to take care of others. Puts excessive blankets on other residents. If another resident doesn't want to eat, (Resident # 99) will give food/fluids to other residents. When staff redirects, (Resident # 99) becomes upset. (Resident # 99) feels like her good intentions are being misinterpreted as bad then is upset. Social Services spoke with nursing staff will place res on the behavior mgmt [management] program to be evaluated. Social Services will continue to support and assist."<br><br>In an interview with the Social Services Director, on 4/13/11 at 8:30 A.M., she indicated this was the first time social services had addressed the behaviors.<br><br>The Nurses Notes, dated 2/15/11 at 4:00 A.M., indicated "Resting in recliner at present. Res has been up the past 45 mins trying to unplug all electrical devices et [and] in and out rooms not easily redirected." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Behavior/Intervention Monthly Flow Record, dated March 2011, indicated "Behavior 1- yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, organize, clean. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, leave and try later."

The Nurses Notes, dated 3/1/11 at 7:00 P.M., indicated "Resident up/down out of chair taken to bathroom 1:1 given without success. Confused PRN Ativan given at this time."

The Nurses Notes, dated 3/6/11 at 9:16 A.M., indicated "Restless all AM. Looking for her mom and phone #. Where is she? Have given bfast [breakfast] and coffee. Ambul (sic) in hall with staff. Looked at reminece (sic) book with her. Gave her phone book, paper and pen to look up phone #. Toileted. Cont [continue] to be restless. Becoming sl [slightly] teary now. Gave Ativan at this time."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The Nurses Notes, dated 3/7/11 at 8:15 P.M., indicated "...Res wants to call mom and husband. Res worried that a little girl has been taken. Staff reassures that no little girls have been taken. Res has been up/down all evening. Res has been folding blankets. Res has been taken to restroom. 1:1 given. Fluids offered but resident refused. Phone book given to resident look at. PRN Ativan given at this time."<br><br>The Nurses Notes, dated 3/9/11 at 6:30 P.M., indicated "Resident up and down in recliner wanting to ambulate with unsteady gait. Became restless, agitated. Offered food and fluids- refused. Offered toileting which was accepted but res still restless. Became anxious wanting to go see her parents, sister and brother (all deceased) tearful and shaky. Gave i [one] Ativan 0.5 mg po at this time. Will monitor effectiveness."<br><br>The Nurses Notes, dated 3/14/11 at 6:00 A.M., indicated "Fall risk continues. Was very agitated, anxious, shaking and unable to calm self. Refusing food and fluids. Gave Ativan 0.5 mg i po at 3:06 AM, eff [effective]..."<br><br>The Social Services Note, dated 3/14/11 no time, indicated "Social Services informed of residents lethargy. Dr (name) to be notified. Social Services will | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | continue to support and assist PRN."<br><br>The Nurses Notes, dated 3/16/11 at 3:30 P.M., indicated "Faxed Dr. (name) the following: 1. Resident has an order for Ativan 0.5 mg i po q [every] 2 hours prn agitated not more than 1.0 mg in 24 hours. 2. Dau (daughter) would like order changed to 0.25 mg po q 2 hours prn agitation- not more than 0.5 mg in 24 hours due to causes over sedation for many hours/shifts. Spoke with dau (name) this AM over phone."<br><br>The Nurses Notes, dated 3/17/11 at 10:40 A.M., indicated "NO [new order] per Dr (name) to DC [discontinue] Ativan 0.5 mg PRN change to 0.25 mg po q 2 hours PRN for agitation not more than 0.5 mg in 24 hours d/t over sedation for many hrs/shifts..."<br><br>The Social Services Note, dated 3/24/11 no time, indicated "Dr (name) in today to follow up with (Resident # 99) regarding her progress. Social Services will continue to support and assist PRN."<br><br>The Behavior/Intervention Monthly Flow Record, dated April 2011, indicated "Behavior 1- yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | change position, adjust room temperature, back rub, call family, have her sweep and clean. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, leave and try later."<br><br>The Assistant Director of Nursing provided a Behavior Intervention Detail Report, on 4/13/11 at 8:15 A.M. The report was for behaviors exhibited by Resident # 99 since October 2010. The form indicated from 10/15 to 10/30/10, Resident # 99 had 17 behaviors in which staff attempted 37 interventions with 7 of those being effective, from 11/1 to 11/30/10 Resident # 99 had 38 behaviors in which staff attempted 89 interventions with 8 of those being effective, from 12/2 to 12/31/10 Resident # 99 had 12 behaviors in which staff attempted 24 interventions with 6 of those being effective, from 1/7 to 1/31/11 Resident # 99 had 21 behaviors in which staff attempted 44 interventions with 9 being effective, from 2/1 to 2/15/11 Resident # 99 had 11 behaviors in which staff attempted 21 interventions with 5 being effective, and from 3/2 to 3/19/11 Resident # 99 had 3 behaviors in which staff attempted 3 interventions with no intervention effective. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0309 SS=G | In an interview with the Assistant Director of Nursing, on 4/13/11 at 8:30 A.M., she indicated the care tracker system is<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on interview, observation and record review, the facility failed to ensure a resident experiencing pain and signs and symptoms of a fracture received prompt care to manage pain and receive prompt treatment for the fracture, for 1 of 10 residents reviewed with injury and complaints of pain following a fall, in the sample of 21. Resident #61.<br><br>Findings include:<br><br>1. Resident #61 was identified on the initial tour of the locked dementia unit, on 4/11/11 at 10:15 A.M., by LPN #19, as having had recent falls and a hip fracture. Resident # 61 was observed on 4/12/11 at 9:30 A.M. in her room | F0309 | F 309It is the policy of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.I. Corrective Action For The Resident Affected:The resident identified was transferred to the hospital, treated for a right hip fracture, and returned to our facility where she received skilled care and therapy until April 22, 2011. Upon her return, staff ensured that she had medication ordered for pain and this is being administered per physician orders.II. Other Residents Having The Potential To Be Affected:All residents who are experiencing pain from a fall have the potential to be affected. The pain management policy was reviewed and evaluated based on current evidence based practice. The policy was updated. (Attachment titled Pain Management).III. Systemic Changes And Steps To Ensure That The Deficient Practice Does | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | in bed. .<br><br>Resident # 61's clinical record was reviewed on 4/11/11 at 10:30 A.M. The most recent Minimum data set assessment (MDS) dated 3/11/11, indicated the resident was severely cognitively impaired, required assistance with bed mobility, transfers and ambulation, and was frequently incontinent of urine. Balance during transitions and walking was not steady, only able to stabilize with human assistance while moving from seated to standing and moving on or off the toilet. The resident had fallen since the last assessment, with no injuries.<br><br>The care plan, dated 10/1/10, included a problem for "Resident at high risk for falls and pain right hip and right groin pelvic area, updated 9/21/10, start date 5/15/2008, FALL 11/16/10 at 1225 a.m." Another problem, dated 9/21/10, for "resident with onset of acute pain in right hip and right groin/pelvic | | Not Recur:Mandatory education will be held with all nursing staff, nurses and certified nursing assistants, on May 4th and 5th, 2011. (Attachment titled Required Education for Nursing Staff). The physician notification policy will be reviewed in detail. (Attachment titled Physician Notification). It was stressed that there are times when it is appropriate to fax the physician and there are times when immediate notification is required, such as for complaints of pain without an order for medication, an increase in pain that is not controlled, a fall, or a fracture. Staff will also be educated about the plan to prevent any delay in treatment for a resident with a fracture. All x-ray results will be reviewed by a second nurse to ensure that nothing is missed. Mobilex, our x-ray provider, will notify the director of nursing of all fractures. If unable to reach the director of nursing, the administrator will be called. Staff members were educated about this process in their April staff meeting, (Attachment titled Nurses Meeting Agenda), and will be again in meetings held May 4th and 5th, 2011. Staff members will also be educated on the pain management policy of the facility. It will be stressed that it is not appropriate to administer a pain medication ordered for a specific area of pain for another area. An audit tool was developed that will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | area." Interventions included: "administer pain meds as ordered," "administer prn (as needed) pain meds as needed, ask res to rate pain scale 1 to 10," "monitor for effectiveness of pain meds, notify MD if pain not controlled with current pain meds...."<br><br>Nurses notes, dated 3/29/11 at 10:45 p.m. indicated "Resident sitting on floor by bed of room (not her own) No bruising/skin tears. No outward signs of broken hips can abduct and adduct both legs without problem. No pop/click heard when moving legs, stood with transfers without problems with assist. Resident complains of left leg pain. Hydrocodone 7.5/500 given at this time. Updated Dr-asked if would like x-ray..."<br><br>The Post Fall Reporting Form indicated: "3/29/11 7:00 P.M. resident had a history of falls, observed on floor in resident's room (not her own), lost strength/weakness, activity during | | be used by the Director of Nursing or her designee to ensure that physician notification is appropriate and timely for all residents who have experienced a fall. PRN medications will also be audited to ensure that they are administered timely and that there are appropriate orders in place. (Attachment titled Fall Audit Tool). IV. Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop. The results of all audits will be reviewed by the Quality Assurance Committee monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the incident was -ambulating in bedroom (not her room), getting up from wheelchair, devices in use-chair alarm and anti roll back device, resident's physical status was weakness and unsteady gait, physician was notified 3/29/11 at 11:00 P.M. Summary of factors contributing to falls: Resident has increased confusion, thought another resident's bed was hers, tried to transfer self from wheelchair to bed by self, future interventions-redirect when needed."<br><br>LPN #1, on 4/11/11 at 12:15 P.M., provided a fax, dated 3/29/11 at 10:50 P.M. which indicated "found on floor-sitting by bed. No bruising/skin tears. No outward sign of broken hips can abduct and adduct both legs without problem-No pop or cluck lick heard when moving legs. Stood with transfers from floor to wheelchair and wheelchair to bed without problem with assist. Resident complaints of left leg pain would | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | you like x-ray?"<br><br>Nurse notes, dated 3/30/11 3:30 A.M. "Resident showered with assist of CNA. Noted right elbow-purple bruise, .5 cm right lateral forearm proximal to elbow, small purple bruise .5 cm right mid thigh lateral aspect 3-4 cm 4 red scrapes, horizontal unopened, right upper leg lateral aspect above knee, small purple bruise, day nurses, ADON, MD notified. ...Resident complains of pain in left leg..."<br><br>Fall follow up documentation, dated 3/30/11 at 5 a.m. indicated, injuries noted-2 bruises on left arm on and near elbow, area of scrape abrasion left upper leg, lateral aspect near knee, 1 bruise red in color .5 cm above knee, 3 reddish line, 6 cm length 1 cm width area not open, comments: "resident complains of leg pain at 2:55 a.m. complained pain being pretty bad. Hydrocodone/APAP 7.5/500 one given effective." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Nurse's notes, dated 3/30/11 8:40 A.M. indicated "complaints of pain left lower extremity, given prn (as needed) Hydrocodone 7.5/500 orally at this time. CNA (certified nursing assistant) reported resident cried out in pain when attempted a.m. care, to attempt care at a later time..."<br><br>Fall follow up documentation, dated 3/30/11 at 12:15 P.M. indicated "question if fracture left lower leg, to request order for x-ray from physician...comments: complains of left groin/left hip pain, screams out with slight attempt with range of motion left lower extremity, complains of pain with flexing left foot in toward had, to request order for x-ray left lower extremity from doctor...resident has stayed in bed with no weight bearing or transferring no ambulation...3/30/11 1:45 P.M. new order x-ray of left hip, femur, knee, tibia, foot."<br><br>Nurses notes indicated: "3/30/11 at | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 12:45 p.m. called Dr...office, requested an x-ray order, to return call..."<br><br>"3/30/11 1:05 p.m. ...from Dr...office called with new order may obtain x-ray of lower left extremity, left hip, femur, knee tibia, foot...called (mobile x-ray service) to do x-rays as soon as possible..."<br><br>"3/30/11 1:15 p.m. received copy of fax from 3/30/11 7:35 A.M. no new order received."<br><br>The Assistant Director of Nursing, on 4/12/11 at 11:00 A.M., provided a fax dated 3/30/11 at 7:30 a.m. sent to the physician which indicated: "right elbow .5 diameter purple bruise right lateral fore arm .5 diameter bruise, right mid thigh lateral aspect 3 red lines, scrape 4 cm by 1 cm no open area, right lateral thigh close to knee small .4 cm diameter purple bruise. Noted 2:45 a.m. gave shower." The physician response to the fax was | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | dated 3/30/11 9:33 a.m.<br><br>Nurses notes indicated:<br><br>"3/30/11 3:30 p.m. (mobile x-ray service) here to x-ray left leg."<br>"3/30/11 430 p.m. (mobile x-ray just left after x-raying left leg. Res screaming in pain during procedure. gave one Hydrocodone 7.5/500 mg tab for pain. will monitor."<br>"3/30/11 6:10 p.m. received results of left hip, left tibia and fibula...acute left subcapital fracture with modest displacement....faxed results to Dr...filed results under x-ray results."<br><br>"3/31/11 8:30 A.M. spoke with Dr...on phone about left hip fracture. Dr...states he will call and speak to residents (family member) and then contact and orthopedic surgeon and call us back awaiting return call..."<br><br>"3/31/11 1015 a.m. ...from Dr...office called with new order to transport via ambulance to...for | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | direct admit..."<br><br>"3/31/11 11 A (hospital) supervisor called to report will need to go to radiology before being admitted to (hospital) per Dr (name of orthopedic doctor)...."<br><br>The medication administration records for March 2011 indicated an order for "Hydrocodone 7.5 mg/APAP 500 one, take one orally every 4 hours as needed for oa/right hip(osteoarthritic) pain." The Hydrocodone was documented to have been given 3/29/11 at 10:21 p.m. and on 3/30/11 2:55 a.m., 8:44 A.M., 3:47 P.M. and 10:55 P.M. No medication was administered on 3/31/11 prior to transport and more x-rays. The controlled drug record indicated the last dose of Hydrocodone administered prior to 3/29/11 at 10:30 A.M. was January 12, 2011. The resident also had an order for acetaminophen 325 mg for pain as needed; this was documented to have last been administered | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3/17/11.<br><br>The facility lacked evidence of having contacted the physician for pain medication ordered for the left hip pain or having administer medication to effectively control the resident's pain in the left hip from the displaced fracture.<br><br>3.1-37(a) | | | |
| F0314<br>SS=G | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed for treatment of heel pressure ulcers for Resident #70 and failed to implement adequate interventions to promote healing of a heel pressure area for Resident #34 resulting in Resident #34's heel pressure area progressing from a | F0314 | F314 Tx/Services To Prevent/Heal Pressure SoresIt is the policy of this facility to ensure that a resident who enters this facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.I. Corrective Action For Residents Affected: | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | fluid filled blister to an unstageable area. This affected 2 of 4 residents, reviewed for pressure ulcers, in a sample of 21.<br><br>Findings Include:<br><br>1. During initial observation tour on 04/11/11 at 10:15 a.m. with Unit Manager (UM) #13 present, Resident #34 was identified as being reliable for interview, as requiring assistance of two staff for transfers, and as having an unstageable ulcer (According to "Pressure Ulcers in the Long-Term Care Setting Clinical Practice Guideline dated 2008, unstageable is defined as - Full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the ulcer bed).<br><br>On 04/12/11 at 10:30 a.m. Resident #34 was observed resting in bed with her right heel on a float. The area was observed to be black in the | | Resident # 34 - The resident is noncompliant in keeping her feet elevated when sitting in a chair or her wheelchair. A pressure relieving boot was applied to the resident that should be in place when she is out of bed. This intervention was added to the care plan and communicated to staff through Caretracker, our electronic documentation system. The resident was educated on this new intervention. Resident # 70 - Staff members were educated that the only time this resident should be without her waffle boots is when she is ambulating or participating in therapy. Her care plan was reviewed and updated.II. Other Residents Having The Potential To Be Affected: All residents having pressure sores or at risk of developing pressure sores have the potential to be affected. The pressure risk assessment score was reviewed for all residents in the facility. The care of all residents at risk of developing a pressure sore and those with pressure sores was reviewed to ensure that the appropriate interventions were in place and the care plan was accurate. See the attached audit tool. (Attachment titled Pressure Ulcer Prevention Audit Tool).III. Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur: Mandatory Education will be held | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | center with skin pulled away from the eschar (black/necrotic tissue) around the bottom with reddened edges<br><br>On 04/12/11 at 12:00 p.m., 12:40 p.m., 1:00 p.m., 1:40 p.m., 4:00 p.m., and 5:00 p.m., Resident #34 was observed in her room, seated in her wheelchair. The resident was observed to be wearing fuzzy socks and to have her feet positioned with the heels of her feet flat on the foot pedals of the wheelchair.<br><br>Interview of Resident #34 on 04/12/11 at 12:40 p.m. indicated she had a "place" on her right heel. The resident indicated she was not aware of how or when the area started.<br><br>Interview of Resident #34 on 04/12/11 at 4:00 p.m. indicated no one had ever said anything to her about keeping her heels elevated while she was in her wheelchair. The resident indicated she had been in her wheelchair since the | | with all of the facility nurses and certified nursing assistants on May 4th and 5th, 2011. (Attachment titled Required Education for Nursing Staff). The pressure ulcer prevention program will be reviewed and the importance of the proper and timely implementation of pressure relieving devices will be stressed. The wound care nurse or designee will audit all new admissions weekly to ensure that the assessments are complete and the appropriate interventions are in place and implemented. The wound care nurse or designee will also assess the care plan of any resident with a pressure ulcer to ensure that the appropriate treatment and interventions are in place. (Attachment titled Pressure Ulcer Prevention Audit Tool).IV. Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop. The results of all audits will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | interview on 04/12/11 at 12:40 p.m. except to get up once to go to the bathroom.<br><br>Interview of LPN #10 on 04/12/11 at 1:00 p.m. indicated Resident #34 was admitted to the facility with a blister on her right heel and the blister had popped and left a "sore."<br><br>Interview of RN #11 (working on the hall Resident #34 resided on) on 04/12/11 at 5:05 p.m. indicated she was not aware that Resident #34's heels had been flat on the wheelchair pedals for 5 hours. After the interview, RN #11 went directly to the resident's room and after several attempts, was able to position the resident's right heel off of the foot pedal with a pillow.<br><br>Interview of CNA #12 (working the hall Resident #34 resided on) on 04/12/11 at 5:30 p.m. indicated Resident #34 sat up in her wheelchair at least half of the evening shift. CNA #12 indicated she had educated the resident about | | reviewed by the Quality Assurance Committee monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

keeping her right heel elevated, but the resident didn't like to lay down.

Interview of CNA #14 on 04/14/11 at 9:45 a.m. indicated the CNA worked PRN (as needed) on the floor Resident #34 resided on, and she was aware the resident was supposed to have her legs elevated when in bed, but had never been told the resident was to have her heels elevated when up in her wheelchair.

Review of Resident #34's clinical record on 04/12/11 at 2:30 p.m. indicated the following:

Resident #34 had diagnoses which included, but were not limited to, high blood pressure, diabetes, osteoporosis, and osteoarthritis.

A "Resident Transfer Report" sheet, dated 12/29/10, indicated Resident #34's heels were "boggy-red."

A nurse's note, dated 12/31/10 at 5:00 a.m., indicated, "Large closed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | blister was noted to (right) heel at (2:00 a.m.) this (night). Heel elevated off bed. (Approximate) measures 6.2 (by) 5 cm....Wound Care Nurse notified. (Medical Doctor) notified...Blister is raised. No discoloration around blister. No bruising noted. Area pink."<br><br>A care plan, dated 12/31/10 with updates of 01/14/11, 01/28/11, and 02/03/11 indicated Resident #34 had a pressure area on her right heel. The "Goal" of the care plan indicated,"Area will show increased improvement and a decrease in size within 2 weeks." Hand written under the Goal section was, "Blister has popped- tx (treatment) as ordered (no date). Area continues brown slough. (Wound Nurse) (new order) visit (every) 2 weeks. Next visit 02/17/11. Care plan interventions - (Antibiotic) per MD order, Treatment as ordered, Monitor for (signs/symptoms) of infection such as increased redness, warmth, or drainage & report to MD as needed, Monitor for lack of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | improvement or need to change (treatment).<br>The care plan lacked documentation supporting positioning of the resident's right heel when up in wheelchair and lacked documentation supporting positioning of the resident's right heel when she is in bed.<br><br>A nurse's note, dated 12/30/10 at 1:05 p.m., indicated Resident #34 was cooperative and pleasant and compliant with being turned and repositioned.<br><br>A nurse's note, dated 01/19/11 at 1:30 p.m., indicated, "...Right heel has (changed) over the week; skin under popped blister has turned yellow and measures 4 cm (by) 4 cm (with) black bruise measuring 2.5 cm (by) 1.5 cm; (physician) notified of (change) & asked if OK to consult (wound specialist); OK given;....(Bilateral) heels elevated off bed; in chair for most of shift...+1 edema to (right lower extremity)...." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

A nurse's note, dated 02/03/11 at 12:00 p.m. indicated, "Updated (Medical Doctor) (with) wound nurse recommendations and orders received. (1) cleanse wound (right) heel (with) saline (with) each (dressing) change, apply skin prep. Allow to dry (periwound. Apply Allevyn thin. Seal edges with skin pep. Change (every) 3 days. Next wound care visit 02/17/11 at 2:00 p.m."

An "MD Progress Note," dated 02/17/11, indicated, "Wound Care Note: Unstageable pressure ulcer (right) heel. Covered 100% black eschar. Eschar beginning to pull away from edges. Dimensions 3.8 x (by) 3.7 cm. Periwound intact. Area tender to palpation. Small (amount) serous drainage present on removed dressing. Will continue with Allevyn thin to assist (with) autolytic debridement of eschar. No new orders. Next (appointment) 3/3/11." This entry was signed by the wound nurse.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

A nurse's note, dated 03/05/11 at 7:35 a.m., indicated, "...(Resident #34) pleasant and cooperative. (Alert & oriented (times) 3. Makes needs known...Makes needs known...Edema continues to right lower extremities...."

A nurse's note, dated 03/10/11 at 2:30 p.m., indicated,"(Right) heel wound assessed & measured today. Area measure 4.0 cm x (by) 4.7 cm (width). Depth is unable to determine. Area is unstageable due to the wound bed being covered (with) black eschar (necrotic tissue). (Continue) current (treatment) of cleanse (with) (Normal Saline), apply Santyl to eschar, apply collagen (wound dressing) & cover (with) foam dressing. Will measure again in (1) week. (Treatment to be done daily.)"

Copies of "Daily Wound/Skin Healing Records" were provided by the DON on 04/12/11 at 11:00 a.m.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The records indicated the following:<br><br>On 12/31/10 Resident #34 had a stage 2 "closed blister" was found on Resident #34's right heel. According to "Pressure Ulcers in the Long-Term Care Setting," dated 2008 - a stage 2 pressure ulcer is defined as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough. May also present as an intact or open/ruptured serum-filled blister."<br><br>On 01/03/11 Resident #34 had an "intact fluid filled blister" on her right heel.<br><br>On 01/06/11 the blister was open and measured 3 cm (centimeters) by 4 cm. The record indicated the "top skin was peeled off."<br><br>On 01/09/11 a stage 2 area remained on Resident #34's right heel which had a "pink/beefy red" wound bed. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

On 01/14/11 a stage 2 area remained on Resident #34's right heel. The record indicated the wound bed was a "black/purple bruise."

On 01/16/11 a stage 2 area remained on Resident #34's right heel and the wound bed was "brown and healing."

On 02/21/11 the area on Resident #34's right heel was unstageable and had Alleyn (sic) (wound dressing) "thin in place."

On 02/25/11 area on Resident #34's right heel was unstageable, brown and had serosanguinous drainage. (This entry was the first to indicate drainage from the wound).

Wound healing records, dated 02/26/11 through 03/18/11 indicated there was no change in the wound.

On 03/21/11 the unstageable area

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | on Resident #34's right foot had purulent drainage, a "moderate" odor, an "eschar" (black) wound bed and edematous surrounding tissue.<br><br>Wound healing records, dated 03/23/11, 03/24/11, and 03/26/11 indicated no change in the wound area.<br><br>Wound healing records, dated 04/09/11, 04/10/11, and 04/11/11 indicated the only change in the wound was the odor had decreased to a "slight" odor.<br><br>A MDS (minimum data set) assessment, dated 01/11/11, indicated Resident #34 was alert and oriented and understood what others said to her and was understood by others. The assessment indicated the resident had impaired range of motion with her lower extremities, required extensive assistance of staff for transfers and had (1) stage 2 pressure ulcer. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

A physician's re-write order for March 2011 included the following orders:

An order, dated 01/03/11, indicated, "elevate bilateral heel & apply skin remedy three times a day."

An order, dated 01/03/11, indicated, "Cleanse ulcer on (right) heel, apply Santyl & cover with Allevyn thick and secure with cover roll & change daily."

An order, dated 03/03/11, indicated,"Cleanse ulcer on (right) heel (with) (normal saline), apply Santyl (wound treatment) to eschar only, cover (with) Allevyn thick & secure (with) cover roll - (change) daily.'

A Therapy note with a start of service date of 12/31/10 indicated the resident's discharge plans were to, "Discharge home and independent with caregiver."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident #34's clinical record lacked documentation supporting Resident #34 being non-compliant with positioning and lacked documentation on resident being educated on importance of keeping heel elevated while up in wheelchair.<br><br>Interview of the DON on 04/14/11 at 10:15 a.m., indicated bed pillows wouldn't work for keeping the resident's heel elevated off of the wheelchair pedals due to sliding off. The DON indicated she would talk to Therapy about getting something to use on the wheelchair pedals so the resident's heel would be elevated off of pedals when she was up in her wheelchair.<br><br>The facility failed to provide documentation supporting CNAs and nursing staff were educated on interventions to keep Resident #34's heel elevated while she was sitting up in her wheelchair.<br><br>2. On the initial tour, on 4/11/11 at | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 10:15 A.M., LPN # 19 indicated Resident # 70 had dementia and a pressure sore on her left heel which was acquired in the facility. LPN #19 indicated Resident # 70 utilized waffle boots and a heel elevator.<br><br>On 4/11/11 at 4:40 P.M., Resident # 70 was observed to be sitting in a wheelchair in the dining room. Resident # 70 was observed to have a waffle boot on the left foot.<br><br>On 4/12/11 at 8:15 A.M., Resident # 70 was observed to be sitting in a wheelchair in the dining room. Resident # 70 was observed in an activity. Resident # 70 had bilateral socks and shoes on.<br><br>On 4/12/11 at 9:10 A.M., LPN # 21 was observed to remove the dressing on Resident # 70's left heel. The area to the left heel was observed to cover the entire heel. The area appeared as a loose hard callous area covering half the area and a quarter of the area was dark red/purple in color. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

On 4/12/11 at 9:20 A.M., Resident # 70 was observed to be sitting in a wheelchair in the therapy department. Resident # 70 was observed to have bilateral socks and shoes on.

The clinical record for Resident # 70 was reviewed on 4/11/11 at 1:00 P.M. The record indicated Resident # 70 had diagnoses that included but were not limited to dementia with hallucinations and confusion. The MDS [minimum data set] assessment, dated 2/16/11, indicated Resident # 70 had impaired cognition, and required extensive assistance of two with bed mobility and transfers. The assessment indicated Resident # 70 had no pressure areas.

A Care plan, dated 11/26/09, indicated a problem of "Potential for skin breakdown R/T [related to] decreased mobility." The interventions included but were not limited to "Assist res [resident]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | with turning and repositioning Q [every] 2 hrs and PRN [as needed] and Keep heels up off mattress."<br><br>A Care plan, dated 3/1/11, indicated a problem of "Pressure area L [left] heel." The interventions were "1. ATB [antibiotic] per MD order. 2. TX [treatment] as ordered. 3. Monitor for s/s [signs and symptoms] of infection such as increased redness, warmth, or drainage and report to MD as needed. 4. Monitor for lack of improvement or need to change TX. 5. Heel elevator in bed. 6. Waffle boots BLE [bilateral lower extremities]. 7. No shoes."<br><br>A Wound Care Evaluation, dated 3/3/11, indicated ' ...Pressure-Stage II 6.0 x 8.0 x 0.2...Wound bed: pink with partial skin flap in place...Pt [patient] has developed a pressure area to heel that began as a large blister. Has now ruptured leaving open wound with partial skin flap in place requiring treatment... " | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A physician order, dated 3/31/11, indicated " DC [discontinue] Xerofoam and foam drg [dressing] to L heel. Apply skin prep to L heel and dry thoroughly before putting sock and waffle boot on q [every] shift indef [indefinitely]. "<br><br>In an interview with the Director of Nursing and Assistant Director of Nursing, on 4/12/11 at 8:30 A.M., they indicated Resident # 70 had had a decline in condition and was staying in bed or the recliner more. The Director of Nursing indicated the recliner was the issue causing the pressure to Resident # 70's heel. | | | |
| F0323 SS=G | 3.1-40(a)(2)<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on interview, record review and observation, the facility failed to ensure Resident #99 received supervision and interventions to prevent recurrent falls resulting in a fracture, failed to ensure Resident #61 was supervised so she did | F0323 | F 323 Free Of Accident HazardsIt is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | not attempt to transfer herself without assistance and did not wander into others' rooms looking for her bed, resulting in a hip fracture, failed to ensure Resident #98 was supervised in order to prevent falls while attempting to transfer himself and/or go to the bathroom, and to prevent Resident #97 from attempting to help Resident #98 and turn off alarms, for 3 of 10 residents reviewed for falls in the sample of 21.<br><br>Findings include:<br><br>1. On the initial tour, on 4/11/11 at 10:15 A.M., LPN # 19 indicated Resident # 99 had dementia, and has had several falls and a recent fracture. Resident # 99 utilized a wanderguard, chair alarm and bed alarms.<br><br>The clinical record for Resident # 99 was reviewed on 4/11/11 at 11:45 A.M. The record indicated Resident # 99 had diagnoses that included but were not limited to dementia and anxiety. The MDS [minimum data set] assessment, dated 1/20/11, indicated Resident # 99 had impaired cognition, and had no behaviors. Resident # 99 required limited assistance of one with bed mobility, transfers and ambulation. Resident # 99 had 1 fall with no injury and 2 or more falls with injury since the previous | | accidents.I. Corrective Action For Residents Affected:Resident # 61 - The fall risk assessment of the resident was reviewed. The care plan was reviewed and the appropriate interventions are in place including alarms to alert the staff to her attempts to transfer alone. The resident received therapy to increase her strength and activity tolerance, and also to educate staff on safe transfers. Staff education was completed on her care.Resident # 98 - The fall risk assessment of the resident was reviewed. The care plan was reviewed and updated. The resident's spouse attempts to assist the resident without the knowledge of the staff. A wireless sensor is now being used that the spouse cannot disconnect. The alarm sounds at the nurses station not in the resident's room so staff can respond immediately to the spouse's attempts to help her husband. The time of the resident's diuretic has been changed and he is being toileted every hour after 3 PM. Staff education was completed on his care.Resident # 99 - The fall risk assessment of the resident was reviewed. The care plan was reviewed and the appropriate interventions are in place including alarms to alert the staff to her attempts to transfer and ambulate without supervision. She is being evaluated for the benefit of initiating therapy services. An individualized | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | assessment dated 10/20/10.<br><br>A care plan, dated 10/14/10, indicated a problem of "Resident at risk of falling d/t [due to] new admit to facility and hx [history of] wandering. Dx [diagnosis] of dementia." The interventions were "1. Call light within reach with frequent reminders on how to use. 2. Side rails to assist with transfers and bed mobility. 3. Monitor for dizziness and unsteady gait. 4. Monitor B/P [blood pressure] for orthostatic hypotension. 5. Res [resident] ambulates independently. 6. Ensure res wearing proper foot wear."<br><br>The fall risk assessment, dated 10/14/10, indicated a score of 6. In an interview with the Director of Nursing, on 4/12/11 at 10:00 A.M., she indicated a score of 10 or greater indicated high risk for falls.<br><br>The Nurses Notes, dated 10/28/10 at 2:50 P.M., indicated "Res [resident] found on floor in dining room getting ready to sweep when she tripped on robe. Found on knees and hands on floor. In this position at threshold of Activity's office. No c/o [complaints of] pain. No injury noted...robe to be hemmed."<br><br>The 10/14/10 fall care plan was updated on 10/28/10 to include the intervention of "Ensure proper length of clothing (not too | | behavior care plan has been implemented for this resident. Staff education was completed on her care.II. Other Residents Having The Potential To Be Affected:All residents who are at high fall risk have the potential to be affected. The falls policy and procedure was reviewed and evaluated based on current evidence based practice. (Attachment titled Fall Management). The falls policy and procedure includes assessment, planning, intervention, and evaluation to complete the nursing process. The Post Fall Reporting Form is used after the fall and guides the investigation of the fall, prompts physician and family notification, and also interventions to prevent another fall. (Attachments titled Post Fall Reporting Form, Fall Review Note, and 48-72 Hour Fall Review). An evaluation tool is used 48-72 hours after the fall to ensure that interventions are implemented, are appropriate, and are effective. Staff education was completed with the nursing staff regarding the importance of supervision for residents at high fall risk. The importance of hourly rounding was stressed.III. Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur:Mandatory education will be held with all nurses and certified nursing assistants on May 4th and 5th, 2011. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | long)."<br><br>The Nurses Notes, dated 10/30/10 7:00 P.M., indicated "This nurse observed res sitting upright on shower room floor...Observed 3 cm x [by] 0.2 cm skin tear to chin...(3) steri strips applied small amt blood present. Res stated I was putting plates in the cabinet. Intervention: 15 min checks by staff. Clothing was of proper length along with proper footwear worn..."<br><br>The 10/14/10 fall care plan was updated on 10/30/10 to include the intervention of "Begin 15 min checks."<br><br>The Nurses Notes, dated 11/1/10 at 9:10 A.M., indicated "Met with direct care staff to review interventions put in place with fall of 10-28-10, interventions being utilized and effective."<br><br>The Nurses Notes, dated 11/1/10 at 9:20 A.M., indicated "Met with direct care staff to review fall of 10-3-10 (sic), current intervention of 15 min checks in place, care planned and on alert sheet."<br><br>The Nurses Notes, dated 11/7/10 at 2:00 A.M., indicated "Res found on floor in room (number). Res lying on R [right] side, back facing door to bedroom. Res with no clothes on and lying near urine. | | (Attachment titled Required Education for Nursing Staff). Included in the staff education is a review of the fall management policy, how to do a thorough fall assessment, a review of the forms to complete that prompts the proper investigation of the fall and the proper notification of the physician and family. It will be stressed that the investigation must include critical thinking that asks questions to get to the root cause of the fall. All interventions should address the root cause. Staff members will be educated to look at intrinsic, extrinsic, and systemic causes. After the education, new fall risk assessments will be completed on every resident. An audit tool was developed to be used by the Director of Nursing or her designee to evaluate and monitor staff's adherence to the policy and to ensure that the proper care of the resident occurs. Items included in this audit are the date and time of the fall, the date and time of physician notification, the type and appropriateness of the notification, and the use of pain medications to treat any injury. (Attachment Fall Audit Tool).IV. Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Bed that resident slept on needed to be stripped d/t [due to] being dirty and stained. Assessment completed...Gripper socks on at this time. Res does have glasses but not worn at this time. 5 cm x [by] 6 cm (1 cm depth) purple goose egg L [left] forehead. Bed pushed up against wall. Floor sensor mat laid to side of bed not up against floor. Call light placed to where resident could reach. Reminded resident that if needing help press call light..."<br><br>The 10/14/10 fall care plan was updated on 11/8/10 to include the intervention of "Toilet at 1:00 A.M."<br><br>The fall risk assessment, dated 11/15/10, indicated a score of 6. The assessment indicated Resident # 99 had no falls in the last 3 months.<br><br>The Post Fall Reporting Form, dated 2/11/11 at 9:00 P.M., indicated "...Date of fall: 2/11/11. Time of fall: 9:00 P.M...Observed on the floor (unwitnessed)...Ambulating in hallway...Res worrying self- cleaning, restless going in/out of other resident rooms hitting staff tonight. Given PRN [as needed] Ativan (antianxiety medication)...Based on your evaluation, what are possible care plan interventions to prevent a future fall from occurring? | | stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop. The results of all audits will be reviewed by the Quality Assurance Committee monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Social Service notified about recent behavior..."<br><br>The Nurses Notes, dated 2/11/11 at 10:30 P.M., indicated "...Res stated I lost my balance. I didn't hit my head. No bruising/bleeding/skin tears noted...Had another resident's glasses at her side. Personal glasses and shoes on/worn. Denies hitting head...Res stated I laid head down softly. Lying down on L [left] side, facing towards double doors, head close to fish tank...Called daughter (name). (Daughter name) stated she was falling at home too. It's not medication related..."<br><br>The fall risk assessment, dated 2/11/11, indicated a score of 12.<br><br>The Nurses Notes, dated 2/14/11 at 12:50 P.M., indicated "Met with direct care staff to review fall of 2-11-11, current intervention of therapy referral in place and care planned."<br><br>The 10/14/10 fall care plan was updated on 2/14/11 to include the intervention of "Therapy referral."<br><br>During an interview with the ADoN [Assistant Director of Nursing], on 4/12/11 at 10:00 A.M., she provided the therapy referral completed on 2/26/11 as | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the intervention for the fall on 2/11/11.<br><br>The Post Fall Reporting Form, dated 2/15/11 at 8:10 A.M., indicated "...Date of fall: 2/15/11. Time of fall 8:10 A.M...Res trying to pick up napkin off of floor and lost balance...Res has been having loose stool could be weak from this...Monitor res closely due to acute illness loose stool therapy to evaluate res for need for therapy..."<br><br>The Nurses Notes, dated 2/17/11 at 10:00 A.M., indicated "Met with direct care staff to review effectiveness of intervention with fall of 2-11-11. Intervention of therapy referral delayed due to acute illness."<br><br>The Nurses Notes, dated 2/17/11 at 10:35 A.M., indicated "Met with direct care staff to review fall of 2-15-11 intervention of monitoring res more closely D/T [due to] acute illness being utilized care planned and on alert sheet."<br><br>The Post Fall Reporting Form, dated 2/19/11 at 5:30 P.M., indicated "...Date of fall: 2/19/11. Time of fall 5:30 P.M...Observed on the floor (unwitnessed)...R [right] posterior top of hand bleeding skin tear...weakness from flu, unsteady gait...Based on your evaluation, what are possible care plan | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | interventions to prevent a future fall from occurring? 1. Use clip alarm when in chair. 2. Monitor closely..."<br><br>The 10/14/10 fall care plan was updated on 2/19/11 to include the intervention of "Apply clip alarm."<br><br>The fall risk assessment, dated 2/19/11, indicated a score of 18.<br><br>The 10/14/10 fall care plan was updated on 2/21/11 to include the intervention of "Chair pad sensor."<br><br>The Nurses Notes, dated 2/21/11 at 2:30 P.M., indicated "Met with direct care staff to review effectiveness of interventions implemented with fall of 2-15-11, intervention of monitoring closely D/T acute illness effective."<br><br>The Nurses Notes, dated 2/21/11 at 5:00 P.M., indicated "Met with direct care staff to review fall of 2-19-11, current intervention of chair pad sensor in place care planned and on alert sheet."<br><br>The 10/14/10 fall care plan was updated on 2/22/11 to include the intervention of "Bed alarm."<br><br>The Nurses Notes, dated 2/22/11 at 4:00 P.M., indicated "Res very weak from | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

recent loose stool. Appetite poor. Bed alarm added to res bed due to weakness and res does not always ask for assist."

The Post Fall Reporting Form, dated 2/27/11 at 8:15 P.M., indicated "...Date of fall: 2/27/11. Time of fall: 8:15 P.M...Observed on the floor (unwitnessed)...Stood up while in w/c lost balance and fell to floor...L elbow abrasion no open area to elbow no treatment requested from MD...noticed wire unclipped from box so alarm did not sound...Res sitting in w/c at (hall name) med cart. This nurse also at med cart. I turned away from res for 5 seconds heard thump turned back around and res on L side on floor. Chair alarm wire leading to box was unplugged so chair alarm didn't sound...Monitor and ensure chair pad sensor wires are plugged into clip alarm box..."

The 10/14/10 fall care plan was updated on 2/27/11 to include the intervention of "Monitor and ensure chair pad sensor wires are plugged into clip alarm box at all times."

The fall risk assessment, dated 2/27/11, indicated a score of 10.

The Post Fall Reporting Form, dated 3/11/11 at 4:10 P.M., indicated "...Date of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Fall: 03/11/11. Time of fall: 4:10 P.M....lost balance...chair alarm sounding...Had PT [physical therapy] around 3p- had visitor who left around 4p...Based on your evaluation, what are possible care plan interventions to prevent a future fall from occurring? walk 2 x [times] a shift to increase strength monitor BP [blood pressure] for 1 week..."<br><br>The 10/14/10 fall care plan was updated on 3/11/11 to include the intervention of "Walk 2 x [times] a shift."<br><br>The fall risk assessment, dated 3/11/11, indicated a score of 18.<br><br>The Nurses Notes, dated 3/19/11 at 5:30 A.M., indicated "Res found on floor, sitting in front of recliner in lounge area. Said I was going to pee...c/o [complaint of] L [left] wrist pain, no visible redness or injuries and can move all extremities. Appeared that res slid out of rec [recliner] legs tangled in blanket while attempting to stand (foot rest was down) Res made no sounds while on floor. Weak, confused, using whispering voice. Has recently had acute illness of gastrointestinal infection...Added clip alarm and chair sensor as interventions. Floor mat added for protection next to bed...Also added to use small blankets that are light in weight." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The 10/14/10 fall care plan was updated on 3/19/11 to include the intervention of "Clip alarm."

The 10/14/10 fall care plan was updated on 3/20/11 to include the intervention of "Use small lap blanket in w/c or recliner."

The Nurses Notes, dated 3/21/11 at 2:50 P.M., indicated "Met with direct care staff concerning fall of 3/19/11. Resident has chair sensor, clip alarm has been Dc'd [discontinued]. Staff will use smaller lap blanket while she is in w/c or recliner to decrease possibility of getting tangled in blanket."

The Nurses Notes, dated 3/23/11 at 12:40 P.M., indicated "Met with direct care staff to review effectiveness of interventions implemented with fall of 3-19-11, interventions being utilized and effective."

The Post Fall Reporting Form, dated 4/3/11 at 5:40 P.M., indicated "...Date of fall: 04/03/11. Time of fall: 5:40 P.M...Observed on the floor (unwitnessed)...Getting up from chair...Res sitting on floor. Legs bent at the knees...Did not hit head...Chair alarm...Based on your evaluation, what are possible care plan interventions to prevent a future fall occurring? Monitor

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | closely..."<br><br>In an interview with the Assistant Director of Nursing, on 4/12/11 at 9:00 A.M., she indicated the alarm was sounding when the resident fell on 4/3/11.<br><br>The 10/14/10 fall care plan was updated on 4/4/11 to include the intervention of "When res becomes anxious and getting up frequently involve res in activity."<br><br>The Nurses Notes, dated 4/4/11 at 10:20 A.M., indicated "CNA reported res c/o discomfort R ankle with transfers. Observed R ankle sl [slightly] edematous and res c/o sl discomfort with ROM [range of motion]. Called MD office to report res c/o. Spoke with nurse (name). Awaiting return call."<br><br>The Nurses Notes, dated 4/4/11 at 11:00 A.M., indicated "Met with direct care staff to review fall of 4-3-11, current intervention of when res becomes anxious and getting up freq [frequently], involve her in activity- in place and care planned."<br><br>The Nurses Notes, dated 4/4/11 at 3:20 P.M., indicated "X-ray of R [right] ankle received from (name). This does show a subtle chip fx [fracture] of the R inferior tip of medial malleolus with minimal displacement..." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 4/6/11 at 10:00 A.M., indicated "Met with direct care staff to review intervention of when res becomes anxious and attempting to get up and down, involve res in activities, intervention utilized and effective."

The Post Fall Reporting Form, dated 4/7/11 at 11:00 A.M., indicated "...Date of fall: 04/07/11. Time of fall: 11:00 A.M...was in bed sleeping. Found on floor with back against bed- one hand on siderail (top)- one hand on bedside table... (V) shaped skin tear L [left] lower outer arm. Approx [approximately] 0.5 cm x [by] 0.2 cm. Scant amt [amount] bldg [bleeding]...Summary of factors contributing to fall: weakness continues, recent fall with injury subtle chip fx involving R inferior tip of medial malleolus with minimal displacement. Removed ace wrap R foot/ankle found in bed. Attempting to get out of bed...Based on your evaluation, what are possible care plan interventions to prevent a future fall from occurring? 1. Use nonskid socks when in bed..."

The 10/14/10 fall care plan was updated on 4/7/11 to include the intervention of "Nonskid socks to be worn in bed."

The fall risk assessment, dated 4/7/11,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated a score of 14.<br><br>The Post Fall Reporting Form, dated 4/9/11, at 7:30 P.M., indicated "...Date of fall: 04/09/11. Time of fall: 07:30 PM...Does the Resident have a history of falls? yes. When? last 4-7-11...No apparent injury...Summary of factors contributing to fall: Res sitting in w/c next to (hall name) med [medication] cart. Scooted forward in w/c and leaned over as if to p/u [pick up] something from floor. Res fell out of w/c landing on floor on buttocks...Based on your evaluation, what are possible care plan interventions to prevent a future fall from occurring? 1. Keep res as close to nurses station as possible when up in w/c; engage res in some activity while in w/c to occupy mind..."<br><br>The 10/14/10 fall care plan was updated on 4/9/11 to include the intervention of "Keep close to nurses desk when up in w/c- engage in activity to occupy mind."<br>The fall risk assessment, dated 4/9/11, indicated a score of 16.<br>2. Resident #61 was identified on the initial tour of the locked dementia unit, on 4/11/11 at 9:30 A.M., by LPN # 19, as having had recent falls and a hip fracture, requiring an alarming floor mat, chair clips and preferred to stay in her room most of the time. The resident was | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | observed on 4/12/12 at 9:00 A.M. lying in bed in her room. All alarms were in place and turned on.<br><br>Resident # 61's clinical record was reviewed on 4/11/11 at 10:30 A.M. The most recent Minimum data set assessment (MDS), dated 3/11/11, indicated the resident was severely cognitively impaired, required assistance with bed mobility, transfers and ambulation and was frequently incontinent of urine. Balance, during transitions and walking, was not steady, the resident was only able to stabilize with human assistance while moving from seated to standing and moving on or off the toilet. The resident had fallen since the last assessment, with no injuries.<br><br>The care plan, dated 10/1/10, included the problem "Resident at high risk for falls and pain, right hip and right groin, pelvic area, updated 9/21/10, start date 5/15/2008, FALL 11/16/10 at 1225 a.m." Approaches included: "side rails to assist with transfers and bed mobility, non skid foot wear with transfers and ambulation, ambulate with assist of 1-2 assist, walker and gait belt, keep room free of clutter, let res(resident) feel in control, clip alarm while up in chair, 11/3/10 bed against wall and floor mat beside bed, 11/16/10 gripper socks on at all times, check sensor | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

connections on floor senor, make sure plugged in and all the way, 2/17/11 anti-roll back device on wheelchair, 3/30/11 staff to assist resident into bed after supper."

A fall risk assessment, dated 8/24/10, indicated the resident was at a high risk of falls and was disoriented at all times, with 1 to 2 falls in the past 3 months. A fall risk assessment, dated 2/16/11, indicated the resident was at a high risk of falls.

A nurse's note, dated 8/24/10 at 1:15 p.m., indicated "went to (residents room) to straight cath (catheterize)...Resident was not in bed. Wheelchair next to bed, checked room bathroom. Door was closed, found resident in sitting position with back against wall with legs spread outward. When asked if she hit her head-stated that she did... initiating bed and clip alarms for safety...."

A nurse's note, dated 8/25/10 1 p.m. "Late entry for 8/22/10 at 3:00 A.M. , resident found on floor in training room, resident stated she went into the basement to take a nap, resident was assessed and no sign of injury noted, resident was assisted back to bed..."

During an interview with the facility Administrator, on 4/12/11 at 11:00 A.M.,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | she indicated the training room door should have been locked. She further indicated staff were not sure if the resident had fallen on 8/22 or laid down on the floor.<br><br>A nurse's note, dated 11/16/10 5 A.M. indicated: "CNA (certified nursing assistant) called nurse to resident's room at 12:25 A.M. Res lying on floor on right side with her head next to roommate's bed. Alert and confused. stated 'I was looking for my baby...I don't know how I got here'..."<br><br>A Post Fall Reporting Form indicated: "2/15/11 4:00 P.M. , previous falls on 8/24/10 and 11/16/10, observed on the floor in residents room, probable cause-lost balance, the activity during the incident was: ambulating in bedroom or to/from bathroom, footwear-slippers, non skid socks, what mechanical devices were in use-floor mat alarm, bed rails-2, wheelchair was on other side of room, status of resident at time of falls-incontinence, summary of factors contributing to fall- incontinent of bowel, vomit on bed/shirt getting up from bed unassisted- interventions added; anti-rollback device on wheelchair so will not roll backward when/if resident getting out of bed and wants to use wheelchair." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Nurses notes, dated 3/29/11 at 10:45 p.m. indicated "Resident sitting on floor by bed of room (not her own) No bruising/skin tears. No outward signs of broken hips can abduct and adduct both legs without problem. No pop/click heard when moving legs, stood and transfers without problems with assist. Resident complains of left leg pain. Hydrocodone 7.5/500 given at this time. Updated Dr-asked if would like x-ray..."<br><br>The room the resident was found in on 3/29/11 at 7: P.M. was observed on 4/12/11 at 9:00 A.M. to be on the hallway to the right of the nurses station, the residents room was observed to be on the opposite hallway to the left of the nurses station.<br><br>The post fall reporting form indicated: "3/29/11 7:00 P.M. resident had a history of falls, observed on floor in resident's room (not her own), lost strength/weakness, activity during the incident was -ambulating in bedroom (not her room), getting up from wheelchair, devices in use-chair alarm and anti roll back device, resident's physical status was weakness and unsteady gait, physician was notified 3/29/11 at 11:00 P.M. Summary of factors contributing to falls: Resident has increased confusion, thought another resident's bed was hers, tried to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

transfer self from wheelchair to bed by self, future interventions-redirect when needed."

Nurse notes, dated 3/30/11 3:30 A.M., indicated "Resident showered with assist of CNA. Noted right elbow-purple bruise, .5 cm right lateral forearm proximal to elbow, small purple bruise .5 cm right mid thigh lateral aspect 3-4 cm 4 red scrapes, horizontal unopened, right upper leg lateral aspect above knee, small purple bruise, day nurses, ADON (assistant director of nursing), MD notified. ...Resident complains of pain in left leg..."

Nurses notes dated 3/30/11 8:40 A.M. indicated "complaints of pain left lower extremity given prn (as needed) Hydrocodone 7.5/500 orally at this time. CNA (certified nursing assistant) reported resident cried out in pain when attempted am care to attempt care at a later time..."

Nurses notes indicated the physician office was called on 3/30/11 at 12:45 p.m. to request an x-ray order. Nurses notes indicated the x-ray was taken with results at 6:10 P.M. which included an acute fracture of left hip with modest displacement, "...faxed results to physician.."

During interview with the Director of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Nursing on 4/13/11 at 10:00 A.M., she indicated the resident's alarms did ring on 2/15/11 and 3/29/11, before the fall. She indicated documentation was lacking as to whether the alarm rang on 11/16/10, but had been checked prior to the start of the shift the fall occurred on.<br><br>3. Resident #98 was identified on the initial tour of the locked dementia unit, on 4/11/11 at 10:15 A.M., by LPN #19, as being a high risk for falls, requiring a wireless sensor with alarms on wheelchair, bed and floor mat. Resident #98 was observed on 4/12/11 at 8:30 A.M. sitting in his room with his spouse, Resident #97, who resides in the room with him. Resident #98 was sitting in a recliner with an alarming chair cushion and an alarming pad to the floor.<br><br>Resident #98's clinical record was reviewed on 4/11/11 at 11:00 A.M. Diagnoses included but were not limited to: dementia and senile Parkinson's disease.<br>A history and physical, dated 1/8/11, indicated "neuro: He is alert. He has difficulty answering any questions. He does not seem to have good recollection of recent events. Per his primary care physician he is having increasing memory issues, not taking medications regularly, forgetting appointments. His wife's | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | memory issues are advanced to the point that she gets lost driving through town..."<br><br>The admission MDS(minimum data set) assessment, dated 1/22/11, indicated the resident was interviewable, required assistance with bed mobility, transfers, ambulation, dressing and was frequently incontinent of urine. The assessment indicated the resident had a fall in the past month and the past 2 to 6 months. His balance was unsteady and he was only able to stabilize himself with help with moving from seated to standing, walking, moving on or off the toilet or from surface to surface such as bed to chair.<br><br>The admission assessment detail report, dated 1/16/11 at 7:35 A.M., indicated for safety, the resident was "disoriented at all times, no falls in past 3 months." The personal alarm assessment, indicated the resident was not able to ambulate independently, gait was unsteady, could not walk to and from bathroom on own, continent of urine and bowel, had memory problems and or confusion and had poor safety awareness and/or impaired decision making.<br><br>The falls risk assessment, dated 2/13/10 at 7:45 P.M., indicated the resident was at a high risk of falls, related to intermittent confusion, falls in past 3 months, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | incontinent, and balance problems while walking. Fall risk assessments, dated 2/14/11, 2/21/11, 3/1/11, 3/19/11, 3/21/11, 4/2/11 indicated the resident at high risk for falls and had intermittent confusion.<br><br>The bowel and bladder assessment, dated 1/19/11, indicated the resident was "disoriented and required extensive assistance with transfers, had urge incontinence (requires resident needing to go when feels the urge)." The assessment was not completed to indicate if the resident was able or unable to participate in a retraining or timed voiding program. During interview with the DON on 4/13/11 at 9:30 A.M., she indicated the resident had been continent at the time of the assessment. She indicated staff would increase the times when the resident was taken to the bathroom.<br><br>The care plan, dated 1/16/11, included "fall/safety risk" 1/16/11-keep call light in reach of resident, encourage and reminders to use call light, reminders for safety, need to ask for assistance with mobility, assess residents foot wear-proper fit and non skid soles, therapy as needed, fall safety/risk reminder in residents room, 1/17/11 bed sensor, chair sensor, 1/24/11 change rooms to closer to nurses station, 1/29/11 15 minute checks, do not leave in | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | bathroom alone. Another problem, dated 2/13/11, risk for falls, Fall 2/13/11, fall 3/19/11, fall 3/21/11 included interventions of " 15 minute checks, remind and coach resident to summon aid or nurse for help, discourage spouse from turning off alarms, 2/15/11 chair pad sensor in recliner, 2/21/11 room change, toilet at bedtime, 3/1/11 keep room clutter free, 3/21/11 keep urinal at bedtime, leave door partially open when in room, encourage res to rest in recliner in lounge after supper, 4/2/11 assure chair pad sensor in place in recliner."<br><br>The CNA assignment sheet for the resident indicated: "remind resident and spouse to summoned for assist with ambulation...keep urinal at bedside to keep resident from going to bathroom after supper and frequently ask if need to go to bathroom, toilet at bedtime..."<br><br>A Post Fall Reporting Forms indicated: "Date of fall 1/23/11, time of fall 4:30 A.M. history of falls-yes, observed on the floor in resident's room, was getting out of bed, non skid socks on, mechanical devices in use- bed alarm, bed rails-2 upper, low bed at lowest level, walker, summary of factors contributing to fall resident sleeping in bed. Res was getting out of bed to go to restroom unassisted. Alarm sounded when CNA arrived in | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | room resident was on 1 knee by side of bed. Resident lifted self off floor very well was able to demonstrate to staff what happened, how he slid of bed.'" Fall Follow Up documentation indicated: 1/23/11 2 p.m. - "res continues to get up unassisted throughout the day today" interventions-"will move res Monday or place floor sensor" "1/24/11 250 p.m. "resident still getting up without calling for assistance" and interventions "moved to room (closer to station)."<br><br>"Date of fall 2/13/11, time of fall 6:50 P.M. has a history of falls, Resident's response to why do you think you fell-ambulated to bathroom on his own-chair sensor had basket sitting on it bent over to pick up paper from floor lost balance and fell on right side, observed on the floor, location bathroom, probable cause- balance, lost strength, other cause-short staffed, activity during-ambulating to and from bathroom, what mechanical devices-had basket sitting on alarm-in off position, unsteady gait, based on evaluation what are possible care plan interventions to prevent a future fall from occurring-counseled spouse and resident on importance of alerting staff for assistance; also asked that she not turn off alarms, she admitted to turning off chair sensor. Add to 15 minute checks, is already on every 15 minute checks." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

"2/14/11 6:00 PM has history of falls, came back from bathroom and missed recliner, observed on floor in resident's room, tried to sit but missed chair, ambulating to and from bathroom, what mechanical devices were in use - chair alarm, has in wheelchair not used turned off by wife, floor mat by chair. Based on your evaluation what are possible care plan interventions to prevent a future fall from occurring-additional sensor-wife takes (resident name) from wheelchair to bathroom, bathroom to recliner without telling staff."

"2/20/11 11:40 p.m. getting up to use restroom, observed on floor in resident's room, slipped, ambulating in bedroom, chair and floor mat alarm-both sensors were turned off, physical status at time of fall-incontinence, summary- spouse helped res to a standing position from recliner. Spouse came out in hallway and summoned our help. Res was on all 4's on floor. Both sensors were turned off. Based on evaluation,what are possible care plan interventions to prevent a future fall-separate the couple or devise a different type of sensor that can't be turned off by spouse..."

Fall Follow Up Documentation, dated 2/20/11 at 1140 p.m., indicated the resident was moved closer to the nurse's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | station and would be toileted at hour of sleep.<br><br>A nurses note, dated 2/21/11 at 4:45 A.M. indicated: "Noted door shut to room, had opened door at 3:55 a.m. noted res on side partially lying out of recliner. checked sensors to floor and bed alarm (in chair) tucked in pocket of recliner turned on, tried to recline using push button and res stated that chair won't recline. Manually lifted footrest in reclining position and asked res to please leave sensors on. pulled door 1/2 way shut and also asked to not close completely..."<br><br>"3/1/11 9:45 P.M. Resident response to why do you think you fell? Wasn't finished with his business-wife giving urinal to him and tripped over chair. Incident- observed on floor in resident's room, ambulating in the bedroom, getting out of chair, mechanical devices-chair and floor mat alarm, summary- Resident standing up to use urinal, tripped over chair in front of him, based on evaluation, what are possible care plan interventions to prevent a future fall from occurring? Reminder to wife to ask staff for help, use call light-keep sensor alerts on, keep room clutter free."<br><br>"3/19/11 at 10:50 P.M., Resident's response to why do you think you fell? I | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | sat on edge of bed tried to stand up to urinate, slid off side of bed. observed on floor, resident's room, lost strength/weakness, getting out of bed to urinate, unsteady gait, uses walker,summary-no bed sensor to indicate activity, possible care plan interventions-install bed sensor..."<br><br>"3/21/11 4:15 P.M. wife involved with care of resident's care, observed on floor, ambulating in bedroom, ambulating to/from bathroom, bear feet left foot, chair alarm turned off per wife, bowel incontinence at time of fall, summary-Res ambulation to/from restroom without staff assistance. one sock on and one sock off. sitting down on floor-no pants on. resident doesn't want to ask for staff help, his wife turns off sensors... possible care plan interventions- encourage resident to stay in lounge area until 9 p.m.,.. frequently ask resident if he needs to use restroom."<br><br>"4/2/11 4:40 P.M. Resident's response to fall- I was walking to my wheelchair. observed on floor, residents room, ambulating in bedroom, reaching for walker possibly, floor mat alarm were in use, at time of fall resident incontinent, summary of factors contributing to fall-Chair pad alarm sensor was removed by his wife. res got up from chair legs | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | were weak and he fell on floor, possible interventions to prevent future falls- keep chair pad sensor in place in recliner, check frequently, frequent therapy..." The fall follow up documentation, dated 4/2/11 at 4:40 p.m. indicated interventions of keep wireless chair pad in place in recliner, comments-wife removes sensors-staff reminds of importance of asking for assistance, 4/4/11 5:30 a.m. -spouse removed floor sensor pad from next to bed on 2nd shift, was under bed, asked res and spouse to leave in place for safety...'<br><br>An occupational therapy note, dated 3/13/11, indicated " Patient has experienced recent multiple falls and further decline in function...assessment-Patient presents with deficits in strength, Range of Motion, activity tolerance, balance and cognition influencing ability to participate safely in ADL's and functional mobility...transfer: sit to stand-The patient is able to safely transition from sit to stand requiring moderate assistance with initiation cues..."<br><br>A social service note, dated 4/4/11, indicated "social service spoke with resident regarding his most recent fall...informed res that he needs to use his call light so that nursing staff can assist him with his needs. Resident was | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | agreeable."<br><br>Resident #97's clinical record was reviewed on 4/11/11 at 2:00 P.M. Diagnoses include but are not limited to "dementia." The admission MDS assessment, dated 2/6/11, indicated the resident was cognitively impaired. A fall risk assessment, dated 1/31/11, indicated the resident was disoriented at all times.<br><br>The facility lacked evidence of having provided adequate supervision to keep Resident #98 from attempting to transfer and ambulate on his own to the bathroom resulting in falls and had not updated the care plan to increase the amount of times he was taken to the bathroom.<br><br>3.1-45(a)(2) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0329 SS=D | Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br>Based on record review and interview, the facility failed to ensure nonpharmaceutical measures were attempted to control behaviors prior to the administration of drugs, in that Resident #99 was administered Ativan (anti anxiety medication) and Haldol (an antipsychotic) to control behaviors without evidence of alternate interventions having been implemented, for 1 of 8 residents reviewed with as needed medications ordered, in the sampled of 21.<br><br>Findings include:<br><br>1. On the initial tour, on 4/11/11 at 10:15 | F0329 | F 329 Drug Regimen Is Free From Unnecessary DrugsIt is the policy of this facility to ensure that each resident's drug regimen is free from unnecessary drugs I. Corrective Action For Resident Affected:An interdisciplinary team review was completed on Resident #99 on April 28, 2011 to review her care, identify individualized interventions that would avoid the use of unnecessary drugs, and to provide appropriate activities and diversion. This individualized care plan was communicated to staff through the behavior care plan and through staff education. II. Other Residents Having The Potential To Be Affected: All | 05/10/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A.M., LPN # 19 indicated Resident # 99 had dementia, has had several falls and a recent fracture.<br><br>The clinical record for Resident # 99 was reviewed on 4/11/11 at 11:45 A.M. The record indicated Resident # 99 had diagnoses that included but were not limited to dementia and anxiety. The MDS [minimum data set] assessment, dated 1/20/11, indicated Resident # 99 had impaired cognition, and had no behaviors.<br><br>A Physician order, dated 10/15/10, indicated "...PRN Ativan 0.5 mg Q [every] 8h [hours] po [by mouth] anxiety."<br><br>The Nurses Notes, dated 10/20/10 at 7:30 P.M., indicated "Res back at nurses desk with purse in hand demanding to talk with daughter. Told res she had spoken with her just a few minutes earlier and res did not recall conversation. Stated that she would call her dad to come and pick her up if (daughter's name) couldn't. Unsuccessful with 1:1 [one on one] gave i [one] Ativan (antianxiety medication) 0.5 mg at this time for increased anxiety and nervousness..."<br><br>The Nurses Notes, dated 10/22/10 at 5:00 A.M., indicated "Awake and at nurses | | residents with behaviors have the potential to be affected. An interdisciplinary team review was completed on all residents who exhibit behaviors on April 28, 2011. (Attachment titled Behavior Care Plan Audit Tool). An individualized care plan and interventions were developed for residents that can be used to avoid the use of unnecessary drugs. These care plans are available to all staff in a binder at the nurses station.III. Systemic Changes and Steps To Ensure That The Deficient Practice Does Not Recur: Behavior care plans will be discussed and updated at each care plan meeting and as necessary on the nursing unit. Behavior care plans will also be reviewed in the behavior management meetings at least every six months and as appropriate. Mandatory education will be held on May 4th and 5th, 2011 with all nurses and certified nursing assistants on this plan of correction. (Attachment titled Required Education Nursing Staff). Nurses will be educated that the interventions that are attepted prior to the administration of medication should be documented in the nurses notes. An audit tool was developed to be used by the Director of Nursing or her designee to ensure that all individualized interventions and behavior care plans are followed prior to the administration of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | station from 11 p to 3:30 am. Dressed self carrying purse around wanting to leave. Continuously asking to go home, call daughter, call nephew. Redirected without success. Gave Ativan 0.5 mg at 2:37 am. Went to bed at 3:30 A..."<br><br>The Nurses Notes, dated 10/22/10 at 6:30 P.M., indicated "PRN [as needed] Ativan 0.5 mg given po [by mouth] at this time for increased agitation. Wanting to go home constantly asking to call family even though did talk with family."<br><br>The Nurses Notes, dated 10/22/10 at 10:00 P.M., indicated "Resident into roommate's items clothing/pictures and trying to throw items away. Daughter called, talked with res first then talked with writer. Daughter requested that writer call Dr (name) to see if res could get something else referring to medication. Writer called on call Dr (name). Gave order for Haloperidol (antipsychotic medication) 5mg/ml Give 1/2 (2.5 mg) IM [intramuscular] for agitation. Gave IM in L [left] ventrogluteal with compliance from resident. Prior to giving medication/IM res tried to tear up laminated copy of television channel that was roommate's. Writer took away..."<br><br>A Physician order, dated 10/22/10, | | medication. (Attachment titled Unnecessary Drugs Audit Tool).IV. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of audits, 100% compliance continues, auditing will stop. The results of all audits will be reviewed by the Quality Assurance Committee monthly. . | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

indicated "Give Haloperidol 5mg/ml (2.5 mg) IM for agitation. May give other half later. IM 2.5 mg if still agitated."

The Nurses Notes, dated 10/23/10 at 6:45 P.M., indicated "...Res anxious and nervous. 1:1 given but not effective in calming."

The Nurses Notes, dated 10/23/10 at 7:00 P.M., indicated "Gave Ativan 0.5 mg for anxiety..."

The Nurses Notes, dated 10/24/10 at 8:30 P.M., indicated "Res back and forth from recliner to room to nurses desk wanting telephone book or wanting to talk to her dau [daughter], grandson, sister or brother etc...unsuccessful in re-orienting and 1:1 sessions. Repetitive questions and nervous behaviors. Gave Ativan 0.5 mg i po for anxiety..."

A Physician order, dated 10/24/10, indicated "Haldol 5mg/ml give 2.5 mg now for agitation may give 2.5 in 4 hour if remains agitated."

The Nurses Notes, dated 10/24/10 at 11:35 P.M., indicated "Res anxious and agitated, refusing redirection yelling at nurse. Wanting to go home wanting dau to come and get her. Interrupting report, refusing to sit in recliner. MD notified

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | gave order for Haldol (antipsychotic medication) 5 mg/ml give 2.5 mg IM for agitation now. May give 2.5 mg in 4 hours if remains anxious and agitated."<br><br>A Physician order, dated 10/25/10, indicated "Give Ativan 0.5 mg po BID indef [indefinitely] for anxiety. May give Ativan 0.5 mg po BID PRN for anxiety. DC Ativan q8 hours PRN."<br><br>A Physician order, dated 10/25/10, indicated "Haldol 1 mg IM a 4 hr PRN x [times] 5 days for agitation."<br><br>The Nurses Notes, dated 10/25/10 at 12:35 A.M., indicated "Gave Haldol 2.5 mg IM at 11:50 PM...Continues to be awake agitated at nurses station demanding staff to call daughter, nephew to come and get her. Went to roommate who was sleeping in recliner and shook her and woke her. Redirected again to sit in recliner..."<br><br>A Behavior/Intervention Monthly Flow Record, dated 10/25/10, indicated "Behavior 1. Agitation Yelling wanting to go home. Intervention codes- redirect, 1 on 1, toilet, give food, give fluids, call daughter."<br><br>The Nurses Notes, dated 10/27/10 at 4:30 A.M., indicated "Res awake at 11:15 PM | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | roaming in halls and others rooms going thru roommate's belongings. Packing clothes carrying around. Attempting to get off unit. Wanting to go home. Tried to encourage to lie down in bed, recliner. Gave PB and J [peanut butter and jelly] and 240 (8 ounces) milk consumed both continued to be redirected in others rooms and asking to leave. Gave Ativan 0.5 mg po at 1:39 AM..."<br><br>The Nurses Notes, no date or time, (located between 10/27/10 5:40 P.M. note and 10/28/10 10:00 A.M. note), indicated "Anxious unable to sleep. In and out of bed in and out of room. Unable to be redirected d/t [due to] increased anxiety. Asked nurse for cup of water then stated Is the medicine in here? Res then said the medicine helps her sleep. Gave Ativan 0.5 mg at 12:40 AM..."<br><br>A Physician order, dated 10/28/10, indicated "D/C 8 AM dose of Ativan 0.5 mg d/t [due to] oversedation- continue HS [bedtime] dose and PRN 0.5 mg dose. PRN does to be given q 6 hours for anxiety."<br><br>The Nurses Notes, dated 10/28/10 at 2:15 P.M., indicated "Daughter in to visit resident this afternoon. Noticed that resident seems to be oversedated from Ativan. Requested that Ativan be | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | decreased to only be given at HS [bedtime] and PRN. Called (name) at Dr (name) office and made aware of family request. N.O. [new order] to d/c [discontinue] 8 AM dose of Ativan 0.5 mg d/t oversedation. Continue HS dose and PRN 0.5 mg doses at q [every] 6 hours as needed for anxiety..."<br><br>The Nurses Notes, dated 10/29/10 at 1:00 A.M., indicated "Awake wandering halls into others rooms into roommate's belongings in drawers. Very anxious at 11:15 PM shift change past several nights. Packs and carrys (sic) her belongings around wanting to go home wants staff to call dau nephew to pick her up. Res at nurses station and med carts demanding to get her a bag for belongings. Attempt to redirect distract by offering food fluid magazines word search 1:1. None of these interventions have been successful this shift. Ativan 0.5 mg po at 11:47 PM for anxiety/agitation..."<br><br>The Nurses Notes, dated 10/30/10 at 12:50 A.M., indicated "Resd [resident] highly agitated restless up/down going down hallway entering other resd rooms...Resd going through roommate's clothes out in hallway and back to other rooms. Very anxious becoming upset. Ativan 0.5 mg i given for increased anxiety/agitation." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

The Nurses Notes, dated 10/30/10 at 7:30 A.M., indicated "Res packing belongings in trash can, hers and roommate's. Coming to hall and nurses desk packing up papers any item she can reach others glasses books. Have tried 1:1 had bfast [breakfast] movie low lights denies pain. Unable to redirect Looking sister aunt grandpa and my babies (sic) will monitor."

The Nurses Notes, dated 10/30/10 at 8:00 A.M., indicated "Continues nonstop with above behavior have tried above distractions but res not re-directed. Ativan 0.5 mg po given at this time."

The Behavior/Intervention Monthly Flow Record, dated November 2010, indicated "Behavior 1. A. agitation B. yelling C. wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, give PRN Ativan, give PRN Haldol."

The Nurses Notes, dated 11/1/10 at 12:10 A.M., indicated "Awake and at nurses station at 11 PM. Interrupting during report. Continues with constant questions. Intrusive, looking through papers, folders, lab book, getting into cups and med cups

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | in med cart. Was trying to touch med cards. Was constantly redirected, 1:1, offered food and fluid assisted with putting on pajamas. Wanting to call her grandpa and dad. Found res at door to dining room call light on above door. Door was then locked. Was also walking down hall past her room, entered res room across hall."<br><br>The Nurses Notes, dated 11/1/10 at 3:40 A.M., indicated "Gave Ativan 0.5 mg at 3:03 AM..."<br><br>The Nurses Notes, dated 11/2/10 at 5:30 A.M., indicated "Res anxious, agitated, intrusive, unredirectrable (sic). At nurses station until 2:30 AM gave Ativan 0.5 mg i at 12:20 AM, ineffective. Continued to be anxious, refused to sit or lie in recliner or bed. Rummaging in papers at nurses station. In bed at 2:30 AM had remained in bed since 2:30 AM."<br><br>The Nurses Notes, dated 11/3/10 at 8:45 A.M., indicated "Res up to nurses desk multiple x's [times]. I've got to go home. I've got a doctor's appt [appointment] Where is my pocket book? Where are my keys? I've got to go home. 1:1 [one to one] offered which calmed res some but continued to be worried about needing to be somewhere. c/o [complains of] L [left] cheek discomfort. PRN [as needed] | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Tylenol and Ativan given at this x."<br><br>The Nurses Notes, dated 11/5/10 at 6:50 A.M., indicated "Res has been intrusive into nurses station into all but 2 resident's rooms entire shift. Unredirectable (sic) did several interventions which were ineffective. Gave Ativan 0.5 mg i [one] po [by mouth] at 3:17 AM was ineffective. Continued to go into rooms when residents were sleeping. Awakened several residents attempting to take res's belongings some res became upset attempted to hit this resident. Intervened several times took res out of room. Was yelling this is my house this is my room I can go wherever I want. This behavior continued entire shift res did not sleep from 11p - 7 a. Dayshift nurses notified of res behavior, DON [Director of Nursing] notified. Continues to be awake wandering in res rooms."<br><br>The Nurses Notes, dated 11/6/10 at 7:05 P.M., indicated "Res going in and out of other resident's room. making beds and going through closets/dressers. Very agitated when staff try to redirect. Res raises voice and states Get out of my house! Refused oral meds [medications] at this time: Klonipin (sic) and Depakote. Haldol 0.5 ml given IM R [right] ventral gluteus." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The Nurses Notes, dated 11/8/10 at 3:00 A.M., indicated "Res sitting in recliner at 11 pm trying to get out and go home. Asked to sit several times, clip alarm sounding said she had to get home. Spent 1:1 time, distracted with folding clothes, food, fluid, reading. Interventions unsuccessful continued 1:1 with res. In hallway, dragging blankets, purse and house slippers attempting to go into res rooms. Yelling at staff awaking (sic) residents in rooms. Ref [refused] to sit or lie (sic) in bed. Attempted to give Ativan in ice cream refused. Gave Haldol 2.5 mg IM [intramuscular] in L [left] buttocks at 1:15 AM. Was able to sit in recliner at 1:30 AM..."<br><br>A Physician order, dated 11/8/10, indicated "1. Haldol 0.25 mg (1/2 tab-0.125 mg) po BID behavior abnormality modification. 2. Reduce Haldol IM PRN to 0.25 mg Q2h PRN max 3 doses in 24h."<br><br>A Physician order, dated 11/9/10, indicated "1. Put Klonopin 0.5 on hold- 2 wks. 2. Walk qh today with one or 2...assist. 3. Hold all med- 24h."<br><br>A Physician order, dated 11/10/10, indicated "1. DC Klonopin 0.5 mg po BID. 2. Klonopin 0.25 mg po now and then at 8p tonight. 3. Then Klonopin 0.25 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

mg po at 8A and 4p anxiety. 4. Hold Depakote and Haldol until further evaluation by MD. Resume all other previous meds."

A Physician order, dated 11/10/10, indicated "1. May use Ativan 0.5 mg q [every] 2 h [hours] PRN [as needed] agitation- max [maximum] 1 mg in 24 h. 2. One time dose Klonopin 0.25 mg po at 8 pm tonight."

The Nurses Notes, dated 11/26/10 at 2:10 P.M., indicated "Pharmacists made recommend (sic) after behav [behavior] committee met and discussed res sleeping during day and being awake at noc [night]. She freq [frequently] disrupts other res sleep at noc and isn't easily re-directed. Spoke with pharm [pharmacist] he suggested Melatonin 3 mg hs [bedtime] to help realign her circadian (sic). He said studies have shown good results when someone has to change time zones to adjust "clinically shows it works" no SE [side effects] or sedation. Also this has been discussed at length for this res d/t res ambul [ambulation]/mobility. Spoke with (daughter name) re: above, she said she's ok with this. Told her we will monitor res. Updated Dr (name) waiting response."

The Behavior/Intervention Monthly Flow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Record, dated December 2010, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in to help if necessary. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."<br><br>A Physician order, dated 12/8/10, indicated "DC [discontinue] Haldol 0.5 mg BID [two times daily]. DC Depakote 125 mg po [by mouth] at 12 N [noon] and 6 p."<br><br>The Nurses Notes, dated 12/31/10 at 6:00 P.M., indicated "Called dtr [daughter] to ease anxiety. Pt [patient] very anxious and looking for a way out. Gave prn [as needed] Ativan."<br><br>The Behavior/Intervention Monthly Flow Record, dated January 2011, indicated "Behavior 1- agitation, yelling, wanting to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."<br><br>The Nurses Notes, dated 1/9/11 at 1:15 A.M., indicated "Up/down. Unplugging television. Redirection, 1:1 ineffective. Refused foods/fluids x [times] 1. Redirected to room (number) asking resident if wanted to clean. Refused to clean. PRN [as needed] Ativan 0.5 mg given at this time. Did accept in pudding."<br><br>The Nurses Notes, dated 1/10/11 at 8:43 A.M., indicated "Awake all morning walking around unit looking for glasses. wanting ankle roam alert bracelet cut off. Wanting her sister so she can cut it off. Have tried to redirect with sweeping folding laundry exercise walk 1:1 becoming upset that you won't cut this off | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and call my sister. Gave Ativan 0.5 mg at this time."<br><br>A Care plan, dated 1/12/11, indicated a problem of "Routine use of psychoactive meds with potential for side effects." The interventions were "1. Administer meds as ordered. 2. Monitor for side effects such as dry mouth, urinary retention, constipation, hypotension, etc. 3. Report side effects to MD."<br><br>The Nurses Notes, dated 1/13/11 at 4:00 A.M., indicated "Res awake, wandering in halls and into other's rooms at 11:15 P.M.. Redirected offered food and fluids refused. Poured a cup of apple juice and sat on table for res. Behavior escalated when attempting to redirect. Yelling at staff and resident to get out of my house now or I'm going to call the police. Went behind recliners and pulled electrical cord out of wall for TV. Tried to push on TV screen. Continued to yell at CNAs. Went to res door and tried to pull wreath off door. Asked to come back to recliners, refused and yelled. Sat with res and looked at flower and seed magazine for 1/2 hour, gave Ativan 0.5 i [one] po [by mouth] at 2:06 AM."<br><br>A Behavior Management Team Review, dated 1/27/11, indicated "Summarize the behavioral occurrences. Include number | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | of occurrences in the past 30 days, possible causes, medical considerations, precipitating and contributing factors (if known). Review psychoactive medications to include reduction/increases and any side effects noted. Document team recommendations...Summary- Behaviors Monitored: anger, agitation, bossyness (sic), verbal aggression. Pattern (occurrences/interventions): almost daily. Precipitating Factors: unknown. Psychotropic Medication and Care: clonazepam 0.25 at 6p, lorazapam 0.5 PRN. Recommendation: Refer all to (Psych company name), possible med [medication] change, mini mental assessment to determine type of dementia."<br><br>The Nurses Notes, dated 1/27/11 at 12:00 P.M., indicated "Behav [behavior] mgmt [management] team met re: res increased behav and becoming more difficult to re-direct. Has used Ativan 6 x [times] past mo [month]. Recommend (Psych company name) consult since Dr (name) is back from sick leave. Dr (name) seen res while Dr (name) was out. Updated Dr (name) on this and asked if he's still ok with (Psych company name) seeing res. (Daughter name) states is fine with her."<br><br>The Nurses Notes, dated 1/27/11 at 1:40 P.M., indicated "At desk past hour asking | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

for phone to call (daughter name) near tears have tried 1:1 [one to one] offered drink and snack, magazine and office work. Becoming more upset. Call placed to (daughter name) she spoke with res 5 min. Res crying. (Daughter name) spoke with me and requested I give her Ativan. Gave 0.5 mg at this time."

The Behavior/Intervention Monthly Flow Record, dated February 2011, indicated "Behavior 1- agitation, yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, clean, organize, ask family to come in. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, come/go back later."

The Nurses Notes, dated 2/6/11 at 8:04 A.M., indicated "Res up before 7 A shift. Has been going to other res asking why are you in my house! Who gave you permission? Pointing her finger in their

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | face. Banging fist on desk. Explain why all these people are in my house? Tried talking 1:1 [one to one] with res. refused Bfast [breakfast] offered to dust furniture, wipe tables etc No! I want an answer. Gave Ativan 0.5 mg at this time."<br><br>The Behavior/Intervention Monthly Flow Record, dated March 2011, indicated "Behavior 1- yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep, organize, clean. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, leave and try later.<br><br>The Nurses Notes, dated 3/1/11 at 7:00 P.M., indicated "Resident up/down out of chair taken to bathroom 1:1 given without success. Confused PRN Ativan given at this time."<br><br>The Nurses Notes, dated 3/6/11 at 9:16 A.M., indicated "Restless all AM. Looking for her mom and phone #. Where is she? Have given bfast [breakfast] and coffee. Ambul (sic) in hall with staff. Looked at reminece (sic) book with her. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Gave her phone book, paper and pen to look up phone #. Toileted. Cont [continue] to be restless. Becoming sl [slightly] teary now. Gave Ativan at this time."<br><br>The Nurses Notes, dated 3/7/11 at 8:15 P.M., indicated "...Res wants to call mom and husband. Res worried that a little girl has been taken. Staff reassures that no little girls have been taken. Res has been up/down all evening. Res has been folding blankets. Res has been taken to restroom. 1:1 given. Fluids offered but resident refused. Phone book given to resident look at. PRN Ativan given at this time."<br><br>The Nurses Notes, dated 3/9/11 at 6:30 P.M., indicated "Resident up and down in recliner wanting to ambulate with unsteady gait. Became restless, agitated. Offered food and fluids- refused. Offered toileting which was accepted but res still restless. Became anxious wanting to go see her parents, sister and brother (all deceased) tearful and shaky. Gave i [one] Ativan 0.5 mg po at this time. Will monitor effectiveness."<br><br>The Nurses Notes, dated 3/14/11 at 6:00 A.M., indicated "Fall risk continues. Was very agitated, anxious, shaking and unable to calm self. Refusing food and fluids. Gave Ativan 0.5 mg i po at 3:06 AM, eff | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | [effective]..."<br><br>The Nurses Notes, dated 3/16/11 at 3:30 P.M., indicated "Faxed Dr. (name) the following: 1. Resident has an order for Ativan 0.5 mg i po q [every] 2 hours prn agitated not more than 1.0 mg in 24 hours. 2. Dau (daughter) would like order changed to 0.25 mg po q 2 hours prn agitation- not more than 0.5 mg in 24 hours due to causes over sedation for many hours/shifts. Spoke with dau (name) this AM over phone."<br><br>The Nurses Notes, dated 3/17/11 at 10:40 A.M., indicated "NO [new order] per Dr (name) to DC [discontinue] Ativan 0.5 mg PRN change to 0.25 mg po q 2 hours PRN for agitation not more than 0.5 mg in 24 hours d/t over sedation for many hrs/shifts..."<br><br>The Behavior/Intervention Monthly Flow Record, dated April 2011, indicated "Behavior 1- yelling, wanting to go home. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature, back rub, call family, have her sweep and clean. Behavior 2- Refusing meds. Intervention codes- redirect. 1 on 1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | position, adjust room temperature, back rub, call family, leave and try later."<br><br>The Assistant Director of Nursing provided a Behavior Intervention Detail Report, on 4/13/11 at 8:15 A.M. The report was for behaviors exhibited by Resident # 99 since October 2010. The form indicated from 10/15 to 10/30/10, Resident # 99 had 17 behaviors in which staff attempted 37 interventions with 7 of those being effective, from 11/1 to 11/30/10 Resident # 99 had 38 behaviors in which staff attempted 89 interventions with 8 of those being effective, from 12/2 to 12/31/10 Resident # 99 had 12 behaviors in which staff attempted 24 interventions with 6 of those being effective, from 1/7 to 1/31/11 Resident # 99 had 21 behaviors in which staff attempted 44 interventions with 9 being effective, from 2/1 to 2/15/11 Resident # 99 had 11 behaviors in which staff attempted 21 interventions with 5 being effective, and from 3/2 to 3/19/11 Resident # 99 had 3 behaviors in which staff attempted 3 interventions with no intervention effective.<br><br>In an interview with the Assistant Director of Nursing, on 4/13/11 at 8:30 A.M., she indicated the care tracker system is where the staff document a resident behavior. She indicated the care tracker has a list of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. BUILDING 00<br>B. WING | 04/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHERAN COMMUNITY HOME INC | 111 WEST CHURCH AVE<br>SEYMOUR, IN47274 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | behaviors for staff to choose from socially inappropriate/other, verbally abusive, wandering, resists/rejects care, physically abusive. She indicated when a staff member input the chosen behavior there is a prompt for interventions attempted by that staff member. The interventions are preprogrammed into the system and are the same for each behavior but the person documenting has the option to type in any intervention attempted if not in the list of preprogrammed interventions.<br><br>3.1-48(a)(4) | | | |